

NATIONAL QUALITY FORUM

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DISPARITIES STANDING COMMITTEE

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TUESDAY  
MARCH 28, 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 9:00 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

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  
  
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CHRISTIE TEIGLAND, PhD, Vice President, Advanced  
  
Analytics, Avalere Health | An Inovalon  
  
Company

NQF STAFF:

SHANTANU AGRAWAL, MD, CEO  
DREW ANDERSON, PhD, Senior Project Manager  
IGNATIUS BAU, JD, Consultant  
HELEN BURSTIN, MD, MPH, Chief Scientific Officer  
MADISON JUNG, Project Analyst  
MAURICIO MENENDEZ, MS, Project Analyst  
TARA MURPHY, MA, Project Manager  
ERIN O'ROURKE, Senior Director

ALSO PRESENT:

SHELLEY ARGABRITE, MA, Owner/Operator, Brite U,  
Integrative Wellness Services

JAYNE CHAMBERS, MBA, Senior Vice President,  
Quality, Federation of American Hospitals

KAREN JOYNT, MD, MPH, Senior Advisor to the  
Deputy Assistant Secretary for Planning  
and Evaluation, Office of the Assistant  
Secretary for Planning and Evaluation\*

ROBIN YABROFF, MBA, PhD, Analyst, Office of  
Health Policy, Office of the Assistant  
Secretary for Planning and Evaluation\*

RACHAEL ZUCKERMAN, PhD, Office of the Assistant  
Secretary for Planning and Evaluation\*

\* present by teleconference

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

2 9:14 a.m.

3 DR. ANDERSON: Hi, everyone. Welcome  
4 to day two. So we wanted to start the meeting  
5 today with just a quick recap of what we covered  
6 yesterday.

7 Next slide. Okay. I actually don't  
8 think we have any slides here. So after you all  
9 left last night to go to dinner, the team, the  
10 team came together and we took all of what we  
11 heard through the conversations yesterday. We  
12 took the breakout sheets of the domains and sub-  
13 domains that you identified and we tried to  
14 synthesize everything, and we put them all  
15 together in a revised strawman domain sheet that  
16 you have at your place seating.

17 We also printed the longer list of  
18 domains and sub-domains that we ended on  
19 yesterday, so you can compare the two of them.  
20 And so today what we wanted to do was walk through  
21 the revised list that staff came up with yesterday  
22 and kind of crosswalk between the two and then

1 talk about them section by section just to see  
2 what needs to be revised or moved around or added  
3 or removed.

4 So that's our general approach for this  
5 morning. And then we would also like to get a  
6 better, do a little bit more around potentially  
7 defining some of the high-level domains. But more  
8 importantly, we'd like to get to a more final list  
9 of domains and sub-domains.

10 So it probably would be helpful to just  
11 take a few minutes to take a look at the revised  
12 list and then we can probably just go ahead and  
13 get started going through it section by section.

14 MS. O'ROURKE: Before we do that,  
15 Marshall, do you have any reflections on  
16 yesterday? I know the committee did a lot of hard  
17 work to get some of the important groundwork out  
18 there, so I want to thank everyone for that. And  
19 while people are reading, if there's any thoughts.

20 CO-CHAIR PONCE: I just wanted to thank  
21 everyone. I thought that this was a really  
22 challenging day to plan, and it could, as I told

1 some other people, it could have spun out of  
2 control. But I think it was done in a very  
3 thoughtful way and where we were able to expand  
4 the thinking but then bring it back in. And I  
5 think I want to thank the staff at NQF for helping  
6 with that.

7 CO-CHAIR CHIN: Just the same thing.  
8 Thank you, everyone. It was a fun process, and I  
9 really liked how there was that diversity of  
10 opinion that led to a better project. I think, as  
11 Helen said, that there's a lot more similarities  
12 maybe then we would have expected to, but you can  
13 imagine a situation where it got, like,  
14 contentious or spiraled out of control, but  
15 nothing, it was actually a great creative,  
16 productive synergistic sort of discussion,  
17 disagreement, agreement, consensus.

18 MS. O'ROURKE: So should we walk  
19 through the revised domains? Do you want me to do  
20 this, or do you want to do this?

21 DR. ANDERSON: So we collapsed a lot of  
22 the domains around, I think it was Philip and

1 Helen, and many of you cited some domains that  
2 seemed to fit under this larger bucket of a  
3 commitment to equity, and so we thought that this  
4 was a good way of just capturing the spirit of  
5 leadership around equity, advocating for equity.

6 And so we dropped them into sub-  
7 domains. One is structure for equity, which is  
8 the material context in which care is provided,  
9 such as the buildings, finance staff, and  
10 equipment. And then we put in the idea of system  
11 preparedness, so the capacity or capability to  
12 promote equity, as well as the idea of having a  
13 diverse workforce, and then policy and physical  
14 environment that promotes equity.

15 And then we have the culture of equity,  
16 and this is where we put all the ideas of cultural  
17 competence that's reached through all the levels  
18 that we discussed and the focused areas that we  
19 discussed yesterday. We specifically called out  
20 bias and measuring bias and stigma, which was  
21 something that came up yesterday, as well. And we  
22 put in this idea of prioritizing equity and



1 decision-making, which is more of the higher-level  
2 aspects of using data about disparities and  
3 reducing disparities to drive decisions.

4 So, yes, so with that, I think we could  
5 open it up for just discussion about how this was  
6 organized and if you think anything was missing or  
7 is miscategorized.

8 MEMBER NERENZ: Dave, just one  
9 clarifying question, and it was a little hard for  
10 us phone folks to stay fully in touch this  
11 afternoon, so I may just be clarifying. But  
12 things that you just talked about and I see in the  
13 rest of the document look like they're now  
14 describing properties of organizations, healthcare  
15 organizations or practices. It seems the larger  
16 policy community dimensions are gone. I  
17 personally think that's a good thing. Am I  
18 reading this correctly?

19 DR. ANDERSON: I don't think that was  
20 the intention to have it be focused just on  
21 organizations. I think these, some of them are  
22 more organization-focused, but they're meant to

1       apply to multiple levels.

2                   MEMBER NERENZ:   Okay.   That's why I  
3       asked.

4                   CO-CHAIR PONCE:   Eduardo?

5                   MEMBER SANCHEZ:   I'm not sure where it  
6       belongs, but I seem to recall one of the maybe  
7       sub-domains was about clinical care community  
8       linkages, and it's not called out.   There are  
9       other things that are I think at that level of  
10      specificity, maybe I'm missing it, that are not  
11      necessarily called out.   Am I missing it?

12                  DR. ANDERSON:   We have -- one of the  
13      new domains is cross-sector partnerships to  
14      address social risk factors and promote equity,  
15      and I think the majority of those would fall under  
16      that bucket.   Or do you want one here --

17                  DR. ANDERSON:   I would call it out  
18      specifically.   That seems to me to be a sub-domain  
19      inside the clinical care space, the actual  
20      connection with the community linkage piece.

21                  CO-CHAIR PONCE:   So that would not be  
22      under community engagement, right?   Or elevated up

1       --

2                   MEMBER SANCHEZ:   Like, where it  
3 belongs, I'm not quite sure because one can make  
4 an argument for a number of different places the  
5 way we've organized this, so it's really just a  
6 question of what does it fit best, which domain  
7 does it fit best under.   But I think I could make  
8 a strong argument.   I could be convinced.   I  
9 agree, but, at the same time, I could be convinced  
10 that other places where it might belong.

11                   For example, it could belong on the  
12 equitable provision of high quality care because  
13 it may be that one dimension of high-quality care  
14 is, in fact, having that connection there.   But,  
15 again, I think the cross-sector -- partnership, to  
16 me, is different than a clinical, a clinically-  
17 mediated linkage, if that makes sense.   So when I  
18 think of partnership, I think higher level.   When  
19 I think of the clinical care community link, it is  
20 specifically around the notion of the care that's  
21 being provided out of that clinical setting that  
22 should include not only knowing how to refer to a

1       diabetologist but knowing how to connect to  
2       community services.

3                   CO-CHAIR PONCE:   Okay, thank you.  
4       Nancy, Kevin, then Bob.

5                   MEMBER GARRETT:   So just following up  
6       on David's comment, I also, when I looked at both  
7       of these, it really feels like we're talking only  
8       about provider organizations. And so if the  
9       intent here is to be looking at that whole  
10      ecological model and thinking of the different  
11      kind of rings in which these could apply, which I  
12      thought was Susannah's proposal yesterday, which  
13      I like.

14                   I just feel like we would need to  
15      change the words a little bit. Like the  
16      categories are probably okay, but the material  
17      context in which care is delivered, that really  
18      sounds like you're talking about a provider  
19      organization. But you could imagine structural  
20      things at a policy level, for example, income and  
21      equality is a basic reason why it's hard to  
22      deliver equitable care, the way reimbursement

1 works, kind of the bigger structural issues around  
2 what social services are available in different  
3 areas to help address social determinants.

4 So it just feels like the categories  
5 might be right, but we need to broaden the words  
6 in order to make it apply, although I think heard  
7 David say maybe he thought it was good that it was  
8 only focused on provider organizations. So I  
9 don't know. David, if you want to elaborate on  
10 that.

11 CO-CHAIR PONCE: Yes, I actually was  
12 going to call out David to elaborate on that, too.

13 MEMBER NERENZ: I'm saying something  
14 I've said many times, and I know I'm a minority on  
15 this one. It just seems to me that the core  
16 natural scope of both CMS and NQF is on providers  
17 and measurement they're performing. And so the  
18 more we stay within that domain, the better I like  
19 it.

20 But from our very first meeting, I know  
21 the majority of the group wants, it's much  
22 broader, talk about the social ecological model,

1 talk about social determinants and interventions  
2 at levels far beyond the provider organization.  
3 So I was actually a little surprised to see what  
4 I thought was a focus on the provider level, but  
5 I didn't think the group was going to go there.  
6 And, apparently, the group has not gone there, so  
7 that's okay.

8 CO-CHAIR PONCE: Okay, thank you.

9 Kevin?

10 MEMBER FISCELLA: Well, first, I want  
11 to commend the group on doing a really great job  
12 of distilling an incredible amount of information  
13 in a short period of time. It's really impressive  
14 work.

15 A couple of amendments. Under  
16 structure, I would make sure we have learning  
17 organization in there. And I would say learning  
18 organization, actually that was the original  
19 blanket on the guy who wrote the book on that.  
20 But another organization I think will encapsulate  
21 what we talked about yesterday, I think also under  
22 structure, that's under structure. And also under

1 structure, I think a system for assessing what the  
2 needs of the patient population is. I think that  
3 there needs to be a systematic systems to really  
4 understand what those needs are and then, of  
5 course, a system aligned with adequate resources  
6 to address that. So that, I think, would go under  
7 structure.

8 Under culture, I mentioned them  
9 yesterday, but I'll come back to it, is a culture  
10 of psychological safety, which is absolutely  
11 critical to any discussions of issues around  
12 equity and race. I mean, you know, I think we  
13 know there are many organizations where simply  
14 people don't feel safe using the word racism or  
15 bias. We didn't have the discussion yesterday  
16 around the term bias. And there's certainly many  
17 organizations where I think people would feel very  
18 uncomfortable in raising it.

19 Of course, psychological safety goes  
20 beyond race and ethnicity, but I think that that  
21 fundamental culture is needed. And I think an  
22 appreciation relating to that is an appreciation,

1 which probably goes a little more beyond  
2 psychological safety, an appreciation for  
3 diversity in perspectives, particularly from  
4 people from historically marginalized or  
5 stigmatized groups because I think the culture is  
6 absolutely essential to moving forward.

7 Under the equitable provision of high-  
8 quality care, certainly I would include the issue  
9 of self-management. And I use that in a very  
10 broad sense. But, essentially, I mean systems to  
11 provide patients with the knowledge, skills, and  
12 confidence to manage their healthcare and health  
13 condition. And this is often lacking,  
14 particularly on a systematic way.

15 And the last piece would be I think the  
16 issue of technology and health information  
17 technology that, you know, certainly is becoming  
18 a key facet of healthcare. It has clear  
19 implications for addressing healthcare  
20 disparities, and, if we're not careful, of course,  
21 the risk is that the digital revival actually will  
22 widen healthcare disparities. But I think we



1       should call that out.

2                   CO-CHAIR CHIN:   One question, Kevin.  
3       The subgroup sort of struggled with, like for the  
4       data issue, whether to break it out as a separate  
5       category at the end right now, data and social  
6       risk, or collapse under structure for equity under  
7       commitment to equity. Which would you prefer and  
8       why?

9                   MEMBER FISCELLA:   I don't have strong  
10       feelings about it. I think as long it's really  
11       called out. I think if you were to put it under  
12       data and identification of social risk or probably  
13       -- well, you have social risk factors. I guess  
14       the issue is I think the way it reads right now,  
15       it's not clear that it's really a systematic  
16       approach, and that would, namely I wouldn't  
17       include it under structure for that issue, I mean,  
18       because I can think of many organizations that do  
19       this on a small level. But it really needs to be  
20       systematic. And, you know, I'm thinking, too, you  
21       know, about FQHCs, which are required under the  
22       statute to do a needs assessment in the community.

1       So that's a piece of it is the community needs  
2       assessment, but the other piece is really having  
3       fine-drained data on your patients and really  
4       attempting to do that in a systematic continuous  
5       way.

6                   CO-CHAIR PONCE:   So what about if we  
7       put, Kevin, for commitment to equity, we have  
8       structure for equity and, hearing Nancy's comment,  
9       expanding that culture of equity with all of the  
10      suggestions you made on psychological safety,  
11      appreciation for diversity, and then have a data  
12      for equity and then move that data and  
13      identification of social risk all the way up for  
14      data for equity. And then add there the linkages  
15      just to technology.

16                  MEMBER FISCELLA:   Yes. I think so  
17      because it also really does signal a commitment to  
18      equity if you're doing these things. But if you  
19      wanted to know how serious is an organization  
20      about it, let's look at what are all these  
21      processes. And certainly the data part, if you're  
22      not doing that, how can you say you're really

1       serious about this?

2                   CO-CHAIR PONCE:  They're committed to  
3       equity, right.  Okay, thank you.  And still I  
4       think we're going to put your comments in.

5                   MEMBER SANCHEZ:  This is a smart group,  
6       and it's going to get figured out.

7                   CO-CHAIR PONCE:  I'm sorry.  Bob was  
8       waiting, and then I didn't -- then Lisa, then  
9       Romana, then Philip, then Emilio, then Sarah.  Is  
10      that fair?  Okay.  Bob.  Then Nancy may have a --  
11      Bob, go ahead.

12                  MEMBER RAUNER:  He's going to actually  
13      do a little more on Kevin's talk about the data or  
14      lack thereof, and then I think that needs to be  
15      sort of really called out.  Underneath the data  
16      and identification is that we need data for equity  
17      that we don't have right now.  Most of what's out  
18      there is impeding from the ZIP code level and  
19      things like that.  It's not granular enough.  It's  
20      collapsing to just white/non-white.  We need  
21      better patient-level data that includes those  
22      demographic factors because I think that's one of

1 our limited major limitations, and I think it  
2 should be kind of specifically called out that we  
3 need to build that data. Whether it stays under  
4 that major section or whether data for equity is  
5 moved under commitment to equity, we think we  
6 really need to specifically call out the data  
7 that's missing that prevents us from doing what  
8 we're really assessing well, things we need to  
9 assess.

10 CO-CHAIR PONCE: Okay. Lisa and then  
11 Romana, then Phil, then Emilio, then Sarah, and  
12 then back to Nancy. So Lisa.

13 MEMBER IEZZONI: So I guess we've  
14 opened up beyond the first couple of sections that  
15 I thought we were going to be focusing on.

16 CO-CHAIR CHIN: Microphone.

17 MEMBER IEZZONI: It's on, but is it  
18 working?

19 CO-CHAIR PONCE: Maybe if you could  
20 just bring it a tiny bit closer to you.

21 MEMBER IEZZONI: Okay. Because the  
22 electrical outlet here wasn't working. Okay. A

1 couple of points. I think, Kevin, it's great to  
2 have psychological safety. When we've looked at  
3 safety in the disability community, they tend to  
4 focus on emotional safety and physical safety.  
5 And the word emotional is used especially by the  
6 community of people who are in mental health  
7 recovery because they are often kind of  
8 stigmatized, especially when they go into  
9 emergency departments or so on. And so I think  
10 that it is really important to extend beyond  
11 psychological to maybe emotional safety.

12 And we also found that the community of  
13 people with disabilities talked about physical  
14 safety, that if you can't get up on to an exam  
15 table or you're afraid of falling off of an exam  
16 table, that's kind of physical safety, as well.  
17 So that kind of may go into the environment, but  
18 I think that that's something to think about.

19 The data and identified patient social  
20 risk puts this communicative structure at a  
21 disadvantage that I kind of feel responsible for  
22 with helping with the language. I make data,

1       which is kind of an obvious place for me to put  
2       it. And so I've been trying, because it doesn't  
3       really capture what I meant when I kind of raised  
4       the topic yesterday in our rogue group. I  
5       actually might put it under the culture of equity,  
6       kind of a mission that there are generations  
7       literally of people with social disadvantages or  
8       disadvantages of some sort that leads to kind of  
9       challenges in terms of regaining the help that the  
10      healthcare system intends to apply. And so I  
11      think it would be good to have a little bit more  
12      discussion about where that concept, where that  
13      belongs, because I don't think it belongs under  
14      data.

15               I agree that it should be under  
16      commitment to equity. But from Nancy Garrett's  
17      discussion, you know, opening remarks, it sounds  
18      like it could be, if we expand structure, it's  
19      also a structural, like it's a structural  
20      disadvantage. So --

21               MEMBER IEZZONI: But maybe we could use  
22      slightly different words to kind of tease out

1 those nuances so it's clear that one belongs in  
2 one place because they are different nuances.

3 CO-CHAIR PONCE: Yes, thank you.  
4 Romana?

5 MEMBER HASNAIN-WYNIA: Great. So I  
6 actually wanted to get back to Eduardo's  
7 recommendation. I really do think that's a really  
8 important recommendation, and it's an important  
9 distinction between community partnerships and I  
10 think what you're calling community health system  
11 linkages maybe. I think that has to be very  
12 explicit, and the reason that I say that, and this  
13 is now my wearing my old PCORI hat, is when we  
14 were developing large targeted funding  
15 announcements, so focusing on things like  
16 addressing obesity for under-served populations in  
17 primary care practices or the hypertension trials,  
18 we explicitly put into the funding announcement  
19 that the applicants had to show that there were  
20 clear linkages of communication between any  
21 community outreach, so whether it's a DPP or other  
22 type of a program, back to the health systems, so

1       whether it's a practice or a hospital. But that  
2       was very explicit.

3               I think that there's a lot of really  
4       good work being done right now with community  
5       health workers and really trying to understand the  
6       different models for working in the community and  
7       finding that sweet spot where the health system  
8       and the community intersect. I don't think the  
9       evidence base is out there yet, but it is  
10      emergent. So, again, thinking to the future and  
11      where we want our work to go, I think explicitly  
12      calling out that community health system linkage,  
13      either through data systems, EHRs, whatever, is  
14      really, really important in terms of this  
15      structure of equity that we want to promote  
16      because it's a way to get there and it's also a  
17      way to get there that provides a little bit of  
18      direction to health systems that are trying to do  
19      it, versus just putting that within the larger  
20      domain of partnerships because partnerships means  
21      so much more and is so much bigger.

22              I don't know if, Eduardo, that was your



1 intent, but I liked your comment because that's  
2 how I interpreted it.

3 MEMBER SANCHEZ: Absolutely the intent.  
4 I mean, it is absolutely as important to know, to  
5 connect somebody to rental assistance and how to  
6 do it as it is to know who are the best  
7 endocrinologists in town and what should I expect  
8 that endocrinologist to do when he/she sees my  
9 patient.

10 CO-CHAIR CHIN: How about we put it  
11 where Eduardo had mentioned as a possibility under  
12 the equitable provision of high-quality care under  
13 the sub-bullet disparities and then adding a  
14 bullet, this healthcare community linkage?

15 MEMBER SANCHEZ: Again, I'd like to  
16 take a vote.

17 CO-CHAIR PONCE: Phil and then Emilio  
18 and then Nancy.

19 MEMBER ALBERTI: So, first, this is  
20 great. I think it's really an amazing attempt to  
21 kind of organize all of our thoughts from  
22 yesterday. So I don't see this necessarily as

1     like a one-to-one mapping exercise, right? I  
2     think the metrics that we end up developing could  
3     fit into two different domains you could address.  
4     So, you know, where things specifically go, I'm  
5     not sure that we have to figure out the right  
6     spots.

7                 So just a couple of thoughts about  
8     this. So in terms of the partnerships and  
9     linkages, I think the cross-sector partnerships  
10    limits it. It puts it automatically at a higher  
11    level. So I think if we just have a broad domain  
12    of partnerships and linkages, that could be  
13    everything from those individual connections that  
14    we're talking about to the data connections we're  
15    talking about, the actual cross-sector  
16    partnerships in the community. I mean, I think it  
17    could be broader, and I think that's something  
18    like what Romana was just saying in terms of  
19    direct connection through HIT from social services  
20    to the hospital to kind of have that connectivity.  
21    That could be both under that domain of  
22    partnerships and linkages, as well as the

1 structure for equity, because without the  
2 technological infrastructure to promote this work,  
3 it can't go forward.

4 So, again, if we're okay with not  
5 having kind of the actual metrics be unique to a  
6 particular domain, I think that's something that  
7 we could play with.

8 And I also think that it would be  
9 helpful as a next step maybe under each of these  
10 larger domains to specifically list out, and I  
11 think this gets to Nancy's point, you know, those  
12 seven levels of the socio-ecological model and  
13 begin to actually, rather than just kind of willy-  
14 nilly say we could put this here and not there, it  
15 would help guide, I think, our decisions if we say  
16 so what is a metric that really fits into the  
17 provider-level in this domain? Is there  
18 duplicativeness somewhere else? I mean, so I  
19 think maybe that could be important to help  
20 organize where we're going.

21 And the last thing I'd say is that I  
22 think that the data and identification of social

1 risk could absolutely be under the structure for  
2 equity. And I think that, in terms of parsimony,  
3 if you really want to lump into larger groups,  
4 that is such a sine qua non of the work, that if  
5 you don't measure and assess and routinely do that  
6 piece and report and hold folks accountable, I  
7 mean that is really like a cornerstone of the  
8 structure that we're talking about.

9 So I think there is value to calling it  
10 out on its own because it is so important, but if  
11 we want to have kind of a taxonomy that makes  
12 sense, it certainly is a cornerstone of the  
13 structure for equity.

14 CO-CHAIR PONCE: I was just going to  
15 call on Emilio unless you had a comment, Marshall.

16 CO-CHAIR CHIN: Yes, a question for  
17 Philip. I think we just said is certainly one way  
18 to go, like, for example, making it broader, the  
19 partnership domain, so you could have like a  
20 variety of things before I talk about just the  
21 linkage one we just talked about, go there also.

22 One of the reasons why it was separate

1 was to really call it out as a separate topic.  
2 The description yesterday, there was like a white  
3 sheet to three different models. Actually, your  
4 model, Helen's model, which are pretty similar,  
5 and then there was Ignatius's one that had like  
6 the eight different ones. And so there's a lot of  
7 overlap between the three.

8 The things that weren't as explicit in  
9 yours and Helen's were two things that Ignatius  
10 had, which had to do with this cross-partnership  
11 one. Maybe it gets back to like what David said  
12 at the beginning, that the group as a whole, there  
13 was this sense that this social factor issue was  
14 going to be a critically important one. But, I  
15 mean, that was the story of why it was separate,  
16 and it was narrower.

17 So I'm curious, given like tradeoffs  
18 here where the managing of the cross-sector parts,  
19 if you want to highlight that, versus being that  
20 it is more specific. So if you want it to have a  
21 more general flow, then your suggestion made a lot  
22 of sense. I'm curious to know, like, your

1 thoughts or your group thoughts about, like, that  
2 type of choice of like, a choice which basically,  
3 it did highlight sort of the cross-sector social  
4 factor or Romana's point about sort of pushing to  
5 beyond what the healthcare system is right now  
6 versus a more general model.

7 MEMBER ALBERTI: You know, we debated  
8 this, as well. We didn't have partnerships in our  
9 group. We had collaboration, which is our version  
10 of a domain. And I think we went back and forth  
11 whether that should be a separate domain or is  
12 that part of the culture for equity? I mean,  
13 because if you don't have a collaborative culture.

14 And I would also say we don't have the  
15 word inclusion here. I think there are a lot of  
16 great metrics around culture and climate of  
17 inclusion that we could add. We don't have social  
18 mission as part of the culture. I think that  
19 could also be, you know, I know that folks at GW  
20 are really thinking about how to measure the  
21 social mission of an organization that could be  
22 included here.

1                   You know, I think, in theory, we could  
2                   have, you know, this larger commitment, and this  
3                   is all a commitment to equity, right? So that  
4                   domain is also a little bit strange. But, you  
5                   know, I think the structure for equity, culture of  
6                   equity, the access and provision, I do think  
7                   collaboration could fall under culture of equity  
8                   and would allow for both that individual, you  
9                   know, shared decision-making kind of collaboration  
10                  all the way through formal linkages with your  
11                  public health department, transportation  
12                  department, etcetera. And I do think the data and  
13                  identification could fall under structure for  
14                  equity. So then we'd be back to these kind of  
15                  four other domains.

16                 I'm agnostic, I think, I'll open it up  
17                 to everybody else, in terms of whether, you know,  
18                 the collaboration and the data piece are so key  
19                 that they need to be separated out even if they  
20                 might logically fall under another domain.  
21                 Whatever, politically, advocacy-wise, whatever is  
22                 going to make the rubber hit the road with the

1 most traction, I think that's what we should do.

2 CO-CHAIR PONCE: Thank you. Emilio?  
3 And thanks for sending out your article to all of  
4 us.

5 MEMBER CARRILLO: Yes. My comments  
6 actually run in line with that sort of discussion.  
7 If the fourth collaboration that is taking shape  
8 in many settings and crossing over from the world  
9 of education and social services to our healthcare  
10 is collective impact, and there are ways to  
11 measure that, there are ways to apply that. And,  
12 you know, besides or perhaps in addition to  
13 talking about community engagement and multi-  
14 sector collaboration, looking at collective  
15 impact, that's a way to move healthcare upstream  
16 might be positive.

17 Also, just reflecting on the point  
18 about data exchange. I think that we should be  
19 clear that, just as we have regional health  
20 information organizations that are developing and  
21 that can be measured, that those organizations  
22 should include social service, community-based



1 organizations, that they should be brought into  
2 that HIE environment. And to the extent that it's  
3 something that's very measurable and that people  
4 are doing to different extent around the country.

5 So I would make that more explicit, as  
6 well, as collective impact, those two things.

7 CO-CHAIR PONCE: Thank you. Sarah and  
8 then Lisa, then Nancy, and then Ignatius.

9 MEMBER SCHOLLE: I'd also like to say  
10 the staff did a very nice job of collapsing these  
11 things, and I think you've done a nice job of  
12 organizing it. I'd actually like to suggest one  
13 more clump based on the discussion.

14 So, in general, I think if it's an area  
15 that's going to have a lot of, that requires a lot  
16 of work and you want to call attention to it, then  
17 I do think it makes sense to pull it outside of a  
18 list. If it's buried in a list, it's hard to see.  
19 And so I think data on social risk and cross-  
20 sector partnerships to address social risk really  
21 are different from what the healthcare system has  
22 been evaluated on before. And so it makes sense

1 to call them out.

2 But I'd actually consider grouping them  
3 together because it always worries me when we have  
4 something that says we want data without having a  
5 clear action step related to it. And the  
6 partnerships are part of what we want to happen.

7 So I could see pulling those together  
8 because there's two ways that you could share  
9 data. And we have data, I think we're talking  
10 about data at different levels, data for the  
11 community or the neighborhood, as well as data for  
12 individuals. And, likewise, the partnerships  
13 could be for the community, as well as for the  
14 individual, right? So we may want to think about  
15 social risk data and partnerships and then  
16 something that's more about the community and  
17 something that's more about individuals. So I'd  
18 offer that as a way to try to pull together some  
19 of the streams of conversation going on here.

20 I wanted to call out, I just want to  
21 make sure I understood the conversation about  
22 learning system on equity. I see right now it's

1 under culture of equity. I've heard it maybe it  
2 should be under structure for equity. Is this the  
3 quality, you know, a quality dashboard? Is this  
4 a QI effort, incentives for equity? Is that where  
5 that fits? If it is, I think this language of  
6 learning system may be something that is not as  
7 clear as it could be for a broader audience  
8 because the more we can be clear and concrete  
9 about what we expect, the better. And maybe I'm  
10 not understanding all the theory behind the  
11 learning system, but some of this has to do with  
12 stratified reporting and public reporting, and so  
13 it could be for the learning system, but it could  
14 also be for more public engagement. And maybe  
15 you'd like for those things to go hand-in-hand,  
16 but maybe they wouldn't always do that.

17 The other comment I had is about  
18 digital, I mean what we have called telehealth.  
19 Here, in other work that we're doing, the term  
20 digital is a broader term that includes both the  
21 synchronous video conferencing along with all the  
22 other ways that you can interact with people using

1       technology. So I would suggest that we consider  
2       changing to that term to be broader because  
3       there's many ways to reach out to people using  
4       electronic tools.

5               And then there was a conversation  
6       yesterday about access to high-cost or high-impact  
7       procedures, and I don't remember who brought this  
8       up, the idea of transplants and cardiovascular  
9       surgery being something that's not always offered  
10      or not always, where we see much lower rates of  
11      uptake in certain populations. And I didn't  
12      actually see that called out here, so I was  
13      curious about whoever made that comment, whether  
14      you see it represented in the equitable access  
15      area.

16             CO-CHAIR PONCE: Traci, did you make  
17      the comment, or is it --

18             MEMBER FERGUSON: Yes, yes, I made the  
19      comment. And I think it's under the address bias,  
20      that if you don't really think about it, it's more  
21      in terms of how can we really see cultural  
22      competency at the provider level as to how they're

1 actually interacting with different members, the  
2 different types of patients. So I think it's in  
3 terms of how we can see cultural competency in  
4 action.

5 MEMBER SCHOLLE: So I actually would  
6 say, you know, from a kind of practical point of  
7 view, I thought the address bias was much more  
8 about the organizational capacity. And if you  
9 want to measure it and see whether there is bias  
10 and what people receive, it's got to be more in  
11 the -- I realize just a framework in the measures  
12 could fit in other places. But I wouldn't have  
13 expected it in that measure. I would have  
14 expected it under equitable access.

15 So just in terms of where it might fall  
16 more easily in terms of the measure, if you wanted  
17 to look and see, was the access to transplants.  
18 Did it differ, it seems to fit better there. So  
19 maybe there's a way to, like someone said,  
20 measures could fit in both places, but I'm not  
21 sure that people would see that as the natural  
22 place to find that kind of measure.

1                   MEMBER FERGUSON: Yes, and I think  
2                   that's where we, when you're talking about address  
3                   bias, looking at all the different levels, so  
4                   there would be sort of a structural in terms of  
5                   the organization level, but then there would be  
6                   another measure eventually or something like that.  
7                   We can do it at the individual provider level.

8                   CO-CHAIR PONCE: Okay. Thank you, and  
9                   thanks, Sarah, because I think you're also putting  
10                  in an appeal of how criteria on what's in, what's  
11                  out, and how to lump and split. So thank you.

12                 Lisa?

13                 MEMBER IEZZONI: Okay, yes. I didn't  
14                 congratulate the staff, but I want to do that now  
15                 in my first comment because I do think that you  
16                 have gone a great job here. And so my comments  
17                 might be more about leaves, so these are trunks  
18                 and branches; is that what we're doing here?

19                 Okay. Either a leaf or a branch under  
20                 equitable access to high-quality care I think does  
21                 need to be timing of services for services  
22                 available at more hours of the day than just

1 during regular business hour. I recently reviewed  
2 some literature that suggests for Medicaid  
3 populations that they're less likely to use  
4 emergency department services if their primary  
5 care providers actually have evening hours and  
6 weekend hours. And so I think that that would be  
7 a nice thing just to add there, and it's very  
8 measurable.

9 And then under communication and  
10 comprehension, I think this is great and we need  
11 to have it here, but it doesn't go far enough for  
12 disability, people with disabilities. It's not  
13 just verbal communication. It's also  
14 communication of information. For example, this  
15 information available in braille, is it available  
16 in, you know, large font. Language access  
17 service, I don't know whether you would also  
18 include CART reporters for example as language  
19 access because it's not actually language, it's  
20 more how you communicate.

21 And I also wonder how you would factor  
22 in communications with people with intellectual

1 and developmental disabilities, the fact that you  
2 might need to communicate in very different ways  
3 to be able to allow them to comprehend what you're  
4 talking about. For example, girls who are about  
5 to get their first Pap smear, oftentimes a  
6 provider might use dolls or something like that to  
7 show what happens during your Pap smear.

8 And so I think that the communication  
9 and comprehension, the language just needs to be  
10 tweaked a little bit to be broader and inclusive  
11 of the kind of things that I've just mentioned.  
12 Thanks.

13 CO-CHAIR PONCE: Thank you, Lisa.

14 Nancy?

15 MEMBER GARRETT: So like Sarah, I worry  
16 a little bit about having social risk factors  
17 hanging out there by itself because we're not  
18 collecting data for the purposes of having data,  
19 we're collecting data for the purposes of doing  
20 something about our new knowledge.

21 So one kind of alternate proposal is to  
22 say, is to have something that says measure and



1 address social risk factors. And that  
2 potentially, like you said, it could go under the  
3 cross-sector partnerships because that addressing  
4 of the social needs is going to have to be much  
5 more than just a health system. And also, like  
6 Sarah said, I mean, it's not something that most  
7 health systems are doing right now, and I'll tell  
8 you it's a tough sell. I mean, all of us are  
9 nodding and saying absolutely we have to have all  
10 the data, but the idea of health systems,  
11 especially if they don't have a lot of populations  
12 that they consider vulnerable, for them to screen  
13 their whole population on these social risk  
14 factors, that's a big investment that they are not  
15 necessarily ready to do. So just know there's a  
16 lot of work and advocacy needed in that area, I  
17 think.

18 And then the second comment is around,  
19 under equitable access, the segregation of  
20 services. I don't think that captures what we  
21 were talking about yesterday. I would call it  
22 segregation of patient populations across

1 providers, and I would put that under structure  
2 for equity. Again, it's not a value judgment. I  
3 mean, there's good and bad about that segregation,  
4 but it's something that we need to understand  
5 because it determines how resources are  
6 distributed and it determines kind of how services  
7 are grouped and that kind of thing. But I think  
8 it's not just about access. It's a broader  
9 concept.

10 CO-CHAIR PONCE: So I got your second  
11 point, but could you elaborate on where to put  
12 social risk factors?

13 MEMBER GARRETT: So one possibility is  
14 to say measure and address social risk factors and  
15 put it under the cross-sector partnerships and not  
16 have a data category.

17 CO-CHAIR PONCE: Okay.

18 MEMBER GARRETT: So to lump the  
19 measuring and addressing together.

20 CO-CHAIR PONCE: Not have a date  
21 category.

22 MEMBER RAUNER: It should be part of

1 all categories.

2 MEMBER GARRETT: But the data on social  
3 risk is one particular kind of data that's new.  
4 We don't have it systematically. And I just think  
5 to have data for data's sake is not a good enough  
6 argument. I mean, it's really what do you need  
7 the data for.

8 CO-CHAIR PONCE: So it's got to be  
9 underneath. Yes, okay.

10 MEMBER GARRETT: That's an idea.

11 CO-CHAIR PONCE: Okay. Ignatius?

12 MR. BAU: So I just wanted to go back  
13 to some of the comments that Kevin and Lisa made  
14 around the safety, psychological, emotional, and  
15 physical, and there's a term cultural safety among  
16 indigenous populations started in New Zealand, and  
17 it's mainly been used in Australia and Canada. So  
18 it's this notion of I need to be safe, feeling  
19 safe, bringing my whole self into the healthcare  
20 setting. And if I'm not, then care can't be  
21 provided to me in an adequate way.

22 So it's just another reference point.

1 We haven't really used it here in the United  
2 States, a little bit in nursing, but it's another  
3 nice concept that we might want to introduce.

4 CO-CHAIR PONCE: I love this group.  
5 Thank you. Emilio.

6 MEMBER CARRILLO: Yes. I think the  
7 possible elephant in the room is having access to  
8 insurance to be able to pay, which is a little  
9 different than affordability. And, again, it's a  
10 politically-charged issue, but it's something that  
11 you definitely have to measure whether someone has  
12 that insurance access as you look at the whole  
13 panoply of challenges to access.

14 CO-CHAIR PONCE: That would be under  
15 equitable access to high-quality care, right?  
16 Okay. Thank you.

17 MEMBER OGBOLU: This is Yolanda, can I  
18 chime in? I'm on the phone.

19 CO-CHAIR PONCE: Oh, hi, Yolanda. Yes,  
20 please, go ahead. I hope you're going to chime in  
21 about --

22 MEMBER OGBOLU: Yes --

1 CO-CHAIR PONCE: -- capital.

2 MEMBER OGBOLU: Yes. I've been  
3 listening to the whole conversation, and I agree  
4 with the team. It was a good job of putting these  
5 things together. I'm looking at still the first  
6 category, commitment to equity, and still feeling  
7 like the title of structure for equity could kind  
8 of encompass kind of all the things that are under  
9 it.

10 The first bullet, structure for equity  
11 and then in parentheses the material context I  
12 think minimizes a little bit of what I thought was  
13 meant by structure for equity yesterday because I  
14 think what we're talking about is more than kind  
15 of the material context. I thought it  
16 encompasses, you know, the culture of equity under  
17 it, which people have been talking about, the  
18 community linkages, and the data for equity and  
19 social risk because they all fall under kind of  
20 structure for equity.

21 And then I just wanted to say something  
22 about the cultural safety versus psychological

1 safety comment that was just made. I think  
2 somebody mentioned it has been used in nursing,  
3 and we do use it. One of the interesting things  
4 when it comes to issues of equity and addressing  
5 bias is that this cultural safety is both at the  
6 patient level and the provider level. Providers  
7 often say they don't feel like they have a safe  
8 environment to be open and admit that they don't  
9 understand how to address some issues related to  
10 bias and also to providing culturally-competent  
11 care. So it's cultural safety for patients and  
12 also for providers.

13 And in terms of you asked a question  
14 about the social cohesion -- pardon me. I'm  
15 sorry. I caught a little cold overnight, which is  
16 why I'm calling from the phone.

17 CO-CHAIR PONCE: It's good that you're  
18 not sitting --

19 MEMBER OGBOLU: Yes. In terms of the  
20 social cohesion, you could look at that as multi-  
21 level. I think somebody mentioned still looking  
22 at things from the policy level and the patient

1 level. I think that's still important, as well,  
2 because when I think about social cohesion, it  
3 could be related to the community linkages in  
4 terms of cohesion between the healthcare  
5 organizations and the community, as well as on the  
6 individual level, the individual patient level, so  
7 I think it can mitigate, you know, social risk.  
8 So if you have better social cohesion, obviously,  
9 you know, it could be protected from some of the  
10 social risks.

11 So those were just the comments I had  
12 from listening.

13 CO-CHAIR CHIN: So I'd like to get at  
14 what Yolanda had mentioned. Marshall here,  
15 Yolanda. I guess this morning the issue of like  
16 domains and isolation versus, in some ways, a  
17 step-by-step delineation of how to achieve equity,  
18 collecting the data, what do you do with the data,  
19 the action of the data.

20 So I think it was like the group in the  
21 corner, it was like Philip and Drew's group,  
22 where, if I recall it right, they were the white

1 sheets that had the closest to that under one of  
2 their domains. I think it was like the equivalent  
3 of their commitment to equity domain, and they  
4 actually had a lot of that mapped out, like the  
5 data collection, then use in quality improvement,  
6 doing interventions, and implementing it all.

7 On one hand, you can try to sort of  
8 build it into like these kind of domains. I mean,  
9 some of the suggestions about like moving data  
10 under the commitment to equity and structure and  
11 look at the quality and etcetera. The other is  
12 that we have our overarching conceptual framework.  
13 Again, that one that has like the data circle, and  
14 then there's like actions, like payment and stuff,  
15 at the bottom. So there could be the linkage then  
16 of the domains mapped to the overarching model.  
17 Well, we could try doing both, but I do hear this  
18 message of like right now, unless like one of  
19 those is done, whether it's like within the  
20 domains themselves or us linking to a wider  
21 district of model, people are finding that it  
22 doesn't, it's not as valuable as people would want



1 it to be, I guess, if the how-to isn't somewhere  
2 there within the domains or else linked to like  
3 our existing model.

4 CO-CHAIR PONCE: I think this is  
5 related, but I think what we're trying to do or  
6 what we've done is kind of a, you know, because  
7 I'm from L.A., so it's sort of, you know, like  
8 Ryan Gosling is like this guy and this guy. So  
9 this is like -- so, okay, I don't really know.  
10 But it feels like it's Donabedian and it also  
11 feels like the social ecological models. And,  
12 Yolanda, you and I know this pretty well that the  
13 WHO social determinants of health model. So it  
14 feels like this kludge of Donabedian, the  
15 structure process outcomes, but then very  
16 provider-centered to this zoomed-out larger model.  
17 So I think we're trying to do both.

18 And then when Romana was saying, like,  
19 how to, these community health system linkages as  
20 how to, so social capital and social cohesion in  
21 the WHO model are actually the mediators between  
22 these big structures, structural, and like

1 governance, big policies, and cultural.

2 So I don't know if -- I'm turning to  
3 Helen -- if we're going to try to put whatever the  
4 accountable entities are, providers, community,  
5 policies, are we putting them on the hook with  
6 measures of accountability and how to? So that's  
7 what, you know -- okay. Romana?

8 MEMBER HASNAIN-WYNIA: I don't know if  
9 this the right time to ask this again, but I know  
10 it would certainly help me. And I know Cara is  
11 not here today, but I've gotten lost again, I'm  
12 lost again in terms of what is it that CMS is  
13 asking for? Because in my mind, or at least when  
14 I was talking to Ninez and Lisa last night, in my  
15 mind, when I've had conversations with Cara in the  
16 past about how does something become sustainable  
17 in the context of CMS, it's because it gets  
18 incorporated into payment. And I asked her what  
19 is it that you need for that to happen, especially  
20 with your equity action plan, and she said  
21 evidence, evidence, evidence, evidence. And  
22 measures but measures with evidence, right?

1                   So, again, I just want to anchor  
2                   myself, and if this is not the right time you can  
3                   have a sidebar conversation with me. I don't know  
4                   if others are a little bit lost. It might help  
5                   just to re-anchor what is it that we're trying to  
6                   produce for our funder right now?

7                   DR. BURSTIN: I could take a crack at  
8                   it. Some other folks from CMS will be maybe  
9                   listening in, as well. If any of them want to  
10                  chime in, operator, please open their lines. I  
11                  think we've been sort of waffling back and forth  
12                  between this sort of micro-view of what's the  
13                  here, the now, the actionable, and not wanting to  
14                  lose the context. So I think it's fine to have  
15                  the broad range, and I, actually, as we were  
16                  speaking, could see sort of visually sort of a  
17                  funnel of what this work looks like. Again, maybe  
18                  it's not linear but it's actually sort of  
19                  something that says we recognize some of this is  
20                  at the broadest level, some of this begins to hone  
21                  in to thinking about where community and clinical  
22                  health system come together, this is where the

1 clinical space could be. And I think you could  
2 logically think about measures that might be for  
3 accountability. Some measures might be the ones  
4 that would get health systems to start moving in  
5 this direction, but not necessarily something that  
6 CMS would pick up on.

7 But, again, if the CMS measure is  
8 something that requires you to kind of take three  
9 steps back, have community partnerships, have data  
10 on social determinants, then can you start to see  
11 it as those are sort of the precursor steps  
12 internally that would start moving you in that  
13 direction, even though at the end of the day they  
14 may get a more narrow lens of true accountability  
15 measures ready for use.

16 But I don't want to lose sight of that  
17 future tense because I do think we have no idea  
18 what this would look like in an alternative  
19 payment model, right? We're still thinking about  
20 this is what a hospital would do, this is what a  
21 doc would do or a nurse would do. What does it  
22 look like when you're paid for a population-based,

1 well, what would it look like when you're going to  
2 have population-based payment? You're going to  
3 have to move in this direction.

4 And so I want to make sure we're ahead  
5 of the game to be thinking about that and get out  
6 of sort of the box of always being sort of stuck  
7 at the bottom of the funnel. Does that help?  
8 Does that make sense?

9 CO-CHAIR CHIN: I'll give it a crack,  
10 too, because I was trying to talk to Cara in  
11 between, like, the sessions and all. I think it's  
12 consistent with what you just said, Helen, that  
13 she would have both a short-term, as well as a  
14 long-term goal. Her goal is basically to improve  
15 equity over time.

16 So for example, an example of a media  
17 goal would be existing data-based purchasing  
18 programs. Well, why can't we build in some type  
19 of equity measures? I mean, that's what we've  
20 been talking about the past couple of days. Why  
21 not? And then some things that maybe longer term,  
22 though not that far off the horizon. So some of

1 the population-based health rings, well, you can  
2 see why it's not a cure yet but shouldn't be that  
3 far away for a lot of the things we're talking  
4 about with social factors, for example, and the  
5 partnerships.

6 Things need to be done in a evidence-  
7 based way. So my sense is like why, like we've  
8 had these four two reports which I think a lot of  
9 it seem kind of distal. I mean, why do we need a  
10 document where we already know regarding  
11 disparities among these five different groups and  
12 all? Well, I think our answer would be that you  
13 need to have this evidence-based approach, so  
14 systematically you've got to describe the  
15 disparities, the second report where we've got  
16 systematically show what the evidence base is  
17 because the measures we're going, that we're  
18 developing, some will be evidence based and some  
19 are going to be aspirational of, well, measure  
20 developers need to develop that. But to be able  
21 to have a validated measure that can fly, well,  
22 it's got to be this evidence base. But the

1 ultimate goal, I mean, a very practical goal of  
2 using the leverage that are available then to  
3 improve equity.

4 CO-CHAIR PONCE: Okay. Susannah, then  
5 Traci, Bob, Kevin. Oh, I'm sorry. Emilio,  
6 actually, you're in front of the line, so go  
7 ahead.

8 MEMBER CARRILLO: Thank you. Just a  
9 couple of thoughts under equitable provision of  
10 high-quality care, the section on interventions to  
11 reduce disparities. One thing that we've touched  
12 on yesterday is the teams. You know,  
13 traditionally, teams have been very professional  
14 with a social worker, psychologist, physician,  
15 nurse. And actually including in the team, as  
16 part of the team, some of the front-line staff  
17 that is more culturally and socially syntonic with  
18 the community served, members of the community  
19 that basically are involved in some of these  
20 aspects of social determinant, including such  
21 individuals in the team. It is an intervention  
22 that could be put forth.

1                   The second comment on intervention  
2           would be, I mean, you know, we have community  
3           health workers, case managers, telehealth, you  
4           know, all sort of like, you know, related but  
5           basically distinct types of interventions, but the  
6           concept of stratification of risk and need which  
7           then leads to the appropriate resource allocation.  
8           The patient that, you know, has a certain high-  
9           risk and need and a care manager should be  
10          allocated with home visits, etcetera, the patient  
11          that with cultural reasons, etcetera, a community  
12          health worker, so the concept of stratification of  
13          risk and need, which is, you know, in the digital  
14          realm and technology realm, as well as just  
15          understanding the clinical consequences.

16                   So those are two recommendations for  
17          interventions that I would make.

18                   CO-CHAIR PONCE: Thank you. Susannah?

19                   MEMBER BERNHEIM: So I missed part of  
20          this morning. I'm trying to pick up on the  
21          threads that people are saying now. I hope I'm  
22          not going to move you backwards at all.



1                   So, first, I like these broad domains.  
2           I think there's plenty of work to do in sort of  
3           fleshing out what's in them. And in line with  
4           what Romana was saying, I mean, I think we can, we  
5           lose an opportunity if we aren't a little bit  
6           aspirational, right? I mean, if we come back to  
7           CMS and say here's what there's really clear  
8           evidence for that you don't have a measure for.  
9           I don't know why we're here, right?

10                   I think these are domains that you can,  
11           there's enough evidence for these domains, right?  
12           I mean, IOM said pretty clearly the places that  
13           are succeeding are committed to equity, right?  
14           You can't have equity unless you have equitable  
15           access to high-quality care and equitable  
16           provision of high-quality care. We know that you  
17           need cross-sector partnerships, and you can't do  
18           any of this without data, right? So I think it's  
19           hard to argue that there's at least some evidence  
20           to support these broad categories.

21                   And then I agree with you, Helen, what  
22           we can start to do is build sub-domains, and we

1 can indicate some of these are, we can find a way  
2 to sort of say, like, you know, there's a ton of  
3 evidence in this area that this is important for  
4 equity and there's less evidence in this area.

5 But I think, as a concept, being a  
6 little bit aspirational about sort of if I'm Cara  
7 and I want to target some areas, what I want to  
8 hear from this group is what are the areas we  
9 should be looking at and where are we missing  
10 evidence and where are we missing measures so that  
11 we can start to drive towards the most important  
12 ones.

13 So I think, I don't think we have to be  
14 limited by the evidence piece. And, again,  
15 there's also a little bit of a difference between  
16 process and outcome measures, right? When we sit  
17 in front of NQF with an outcome measure, we have  
18 to show that there's some evidence that there's  
19 things that hospitals or clinicians can do to  
20 influence that outcome. But it's a little bit  
21 different than the process measures. The process  
22 measures are a little more constrained. There you

1 have to sort of say, like, you know, we have five  
2 RCDs that show if you do this you get better  
3 outcomes.

4 But the outcome measures by themselves,  
5 they are sort of aspirational. They're saying,  
6 you know, there's some, we can see the providers  
7 can move this dot. And so let's measure it  
8 because that's going to incentivize them. So I  
9 think that also gives you some room to be a little  
10 bit more -- I really don't want us to be confined  
11 by sort of providing just what there is evidence  
12 for.

13 The one other thing I was going to say,  
14 and it may not be the moment to say it, but  
15 Marshall and I talked about it earlier, is I think  
16 some of the things we wrestle with we may be  
17 helped by sort of laying out some of our  
18 principles before we get to this. So, you know,  
19 sort of saying, you know, a principle is we think  
20 there's a lot of importance of certain kinds of  
21 collaboration or that you have to focus both on  
22 not just closing the gap but overall performance.

1       There's some things that have come up that may be  
2       useful as a backdrop of principles that we may  
3       want to incorporate, as well. So that was a lot.

4               CO-CHAIR CHIN: To expand on what  
5       Susannah just said, her point was that during  
6       yesterday's discussion there was a lot of great  
7       points that were brought up that may or may not  
8       fit quite this domain chapter that we're writing.  
9       So an example she gave was like Romana's point.  
10      We had that discussion about, like, closing the  
11      gap versus improving the measures for population  
12      where that's ultimately, like, again, the final  
13      report or the recommendation report, somehow  
14      that's dealt with.

15             But if people could start jotting down,  
16      if we have a little time, we'll spend some time as  
17      a group doing this. But if we run out of time,  
18      jot it down and then maybe emailing it to Erin,  
19      something like a parking lot, because it will come  
20      back to us for this report or else for the final  
21      report recommendations but, while we have these  
22      good ideas, not to lose them.

1 CO-CHAIR PONCE: Okay. Bob, then  
2 Traci, then Kevin.

3 MEMBER RAUNER: I was going to ask a  
4 little bit about, again, framing the audience for  
5 this report and what we're going to try to get out  
6 of this report. So in our rural report, what  
7 ended up, it was almost like a punch list of  
8 policy things that needed to be fixed by CMS so  
9 that we could get, you know, some things improved  
10 on the rural side of things.

11 This is, the strawman stuff is seen as  
12 being more of a concept best practiced type paper,  
13 but I hope we're also going to get to the point  
14 where this might be sort of a guide so an  
15 organization like mine would try to remove  
16 disparities, how would we do it, if there could be  
17 like some vignettes and examples for how the  
18 report would be used by somebody not just at CMS  
19 but someone like me at the community level, for  
20 example.

21 So that's just kind of framing all this  
22 and where we're going with it would help.

1 CO-CHAIR PONCE: Okay, thank you.

2 Traci?

3 MEMBER FERGUSON: Yes. And just to  
4 expand on what Bob was saying, as a health plan,  
5 a managed care organization, our customers, CMS,  
6 and the states, we follow, we have our programs as  
7 outlined by CMS, and they very frequently do  
8 promote and disseminate best practices, which they  
9 expect a health plan to follow.

10 So I would think in terms of what we're  
11 providing to CMS is, you know, specific measures  
12 that's shown that there's evidence and we can  
13 address some of these being domains but in terms  
14 of what would be best practice. So for, you know,  
15 Medicaid plans where our population, we have a  
16 very, very high disparities in terms of our  
17 population for Medicare, low-income Medicare  
18 Advantage, and for the Medicaid population, what  
19 would you hold sort of accountable to the health  
20 plans as part of their programs and being able to  
21 write very specifically of what should be part of  
22 their care management program, what should be in

1 terms of best practices. We were talking about  
2 pay-for-performance for your provider group. So  
3 being very explicit because that is going to be  
4 translated very well to health plans who are going  
5 to be helping to provide that structure.

6 CO-CHAIR CHIN: I have a question for  
7 Helen because she was nodding her head when Bob  
8 and Tracy were speaking about this issue of who  
9 the audience is. I want to have clarification.  
10 So like Bob was saying, for example, making sure  
11 that the reports have -- and Traci -- like direct  
12 relevance for like provider groups, as well as  
13 health plans, just how to type of stuff, which I  
14 can imagine being a part of it. But someone said  
15 that's already been done to some extent. So an  
16 example, Susannah's point, like the recent report  
17 they had, like an 80-page report on best practices  
18 for how to take care of at-risk populations.

19 So I could imagine a few paragraphs and  
20 call-outs to some existing resources. The part  
21 that hasn't been done yet is really essentially  
22 CMS being the audience because they have the big

1 lever. So particularly the public reporting and  
2 the payment policy, I mean the money that drives  
3 everything.

4 So I would imagine that that's the main  
5 focus so far, the main audience. But along the  
6 way, we can have some text, as what Traci and Bob  
7 were saying, and refer to other documents that  
8 have done it in more detail.

9 DR. BURSTIN: Well, I think part of  
10 what Bob is saying, and he's absolutely right, and  
11 I think one of the documents sent around last  
12 night was the rural report. You'll see there are  
13 very explicit recommendations at the end. For  
14 example, you know, should form A measure  
15 applications partnership workgroup focus on rural  
16 health and think about next steps. I mean, so you  
17 could think about putting some very directive  
18 things in there. For example, I'll throw this out  
19 there. You know, although we have equity sort of  
20 listed in the measure selection criteria currently  
21 for the way measures get selected at these tables  
22 for the MAP, there's really no teeth there.



1       There's nothing there that explains it or says how  
2       to do it or why you would move in that direction  
3       or how it's prioritized. That could be something  
4       I could easily see being a very clear something  
5       that comes out of this. As measures are selected  
6       for specific programs, equity should be considered  
7       in the following way: extra portion of measures  
8       should have some reflection.

9               I think there is a way to build in --  
10       I'll just say it. I think it's just more teeth  
11       into what tends to be, you know -- the NAM  
12       recommendations are wonderful, right? There's 80  
13       pages of them. But, you know, what is it you  
14       would turn around and say, therefore, health  
15       systems -- and I wouldn't limit it to plans or CMS  
16       either, I think some of this is very directional  
17       at what health systems are doing, as well --  
18       tomorrow could start doing X because in three  
19       steps down the line you'll be measured on why.

20               So I think some of this is being very  
21       truly laying out, back to our term of a roadmap.  
22       There's a series of tollbooths along the roadmap,

1 and so what can we do to get you kind of along  
2 that path but not have it be these measures come  
3 up. These measures come up. Frankly, none of  
4 them get submitted to us. It isn't even that the  
5 MAP doesn't pick them among all the measures  
6 submitted. None of them come forward and,  
7 frankly, because there are so few. But I think  
8 there's ways for us, just as an illustrative  
9 example, to be the teeth, to push harder and say  
10 how it will be done, as I think the rural  
11 committee did.

12 MEMBER BERNHEIM: This is a list of  
13 things you would want incentivized, which is  
14 different than the list of things you're telling  
15 providers to do, right? This more than one piece  
16 of what you're describing, sort of where would you  
17 look for measures, but not dictate what providers  
18 are supposed to do. They're related, but they're  
19 different.

20 DR. BURSTIN: Correct. But I think  
21 there are ways to push harder.

22 CO-CHAIR PONCE: And Kevin has been

1 waiting patiently.

2 MEMBER FISCELLA: A couple of issues.  
3 Actually, I was the one that said the opportunity  
4 for career advancement. I would just make that a  
5 little stronger. Really, I think what I really  
6 mean there, and I'm worried if the language isn't  
7 there right now, it's pretty bland. Everybody  
8 says this is an opportunity. What I'm really  
9 talking about is proactive steps to advance  
10 promotion of people from under-represented groups  
11 because many organizations are committed to work  
12 towards diversity, and they can't find people, yet  
13 they have them in their own organization. And if  
14 they can figure out ways to support that through,  
15 you know, time off, training with community  
16 programs that provide that, you can gradually  
17 improve your workforce diversity.

18 This may be too specific, but I do  
19 think it gets at an issue of power and voice. And  
20 that's the concept of 360 evaluations in our own  
21 medical center. All the chairs and center  
22 directors have 360 evaluations in my own

1 department. All the faculty also have them. And  
2 what that does is it gives staff who are below  
3 somebody in rank and pay a voice in the evaluation  
4 of that person and really helps to level that  
5 power differential in the sense that the person is  
6 included in that. It's a structural issue, but it  
7 clearly has impact on culture.

8 A category that we talked about I think  
9 a fair amount yesterday that I would try to bring  
10 in here somewhere, and that is the issue of  
11 transparency. And I think transparency is a  
12 potential lever for both organizational change but  
13 also for promoting equity since those in power  
14 tend to restrict the flow of information.

15 And just to give some specific  
16 examples, you know, if you want to get care, I  
17 know in Rochester, to figure out how much it's  
18 really going to cost, it's often very hard to do.  
19 You can sometimes go to some of the health plan  
20 websites to get estimates, but I know at my own  
21 institution you have to call a number and they'll  
22 give you an estimate. It's really funky and

1 difficult. And so for people who are very  
2 concerned about cost because they may be low  
3 income, may be in a high deductible, they really  
4 have no idea of what it's going to cost before  
5 they enter. So the costs, the ratings of doctors,  
6 for example, the University of Utah Medical Center  
7 now is posting all of those cap ratings for their  
8 doctors online right next to their pictures. But,  
9 again, there's transparency in that information.

10           You know, ultimately, I think we all  
11 want transparency. That's a big aspirational  
12 thing down the road. Even transparency, for  
13 example, in assistance. In Hill-Burton, one of  
14 our MPH students a few years ago looked at how  
15 patients were informed about health about Hill-  
16 Burton in the Rochester community, and there was  
17 no systematic policy. Some people are told about  
18 what's available, some aren't. And I suspect that  
19 it's very similar in other institutions that there  
20 really is not transparency in what the criteria  
21 are and that you can apply, and all these things  
22 I think are critical to inform choices,

1 particularly for people who may not have other  
2 sources or social networks to get that kind of  
3 information.

4 And then I think, you know,  
5 transparency in stating, you know, our  
6 organization is committed to making a difference  
7 in X on this particular measure and we're going to  
8 come back and report publicly how we did. That's  
9 another level of transparency that I think  
10 communicates to the community, look, we're serious  
11 because we're willing to do this, and we're also  
12 humbled because we realize that in many cases  
13 we're going to miss the mark and we're going to  
14 have to reconnect and bring people together and  
15 say, okay, what can we do differently because we  
16 didn't hit it this year. And transparency can do  
17 all of those, all of those things.

18 You know, the last piece, you know,  
19 this may be a little too -- we may not have enough  
20 data on this yet, but it may be worth putting as  
21 a bookmark, and I think there's pros and cons.  
22 But I think it does have some implications for

1 low-income people, and that is sort of the  
2 converse of value-based payment, which is value-  
3 based design, which is that your design, you know,  
4 we reduce co-pays for things that we know are of  
5 high value. So, you know, if we believe certain  
6 medications are, you know, critical, there may be  
7 no co-pay for that. You know, in some countries,  
8 primary care, which, arguably, is essential,  
9 there's no co-pays for primary care. That's only  
10 been done in a few sectors in the United States.  
11 But, again, that would have particular benefit to  
12 somebody who's low income that they're not paying  
13 the same co-pays or having to meet whatever  
14 deductibles on their value-based design. I think  
15 it's worth at least bookmarking that for further  
16 thought and consideration.

17 CO-CHAIR PONCE: Thanks, Kevin.

18 Ignatius.

19 MR. BAU: So I just wanted to say a few  
20 words about advocacy and policy because that's not  
21 something that we talked about. So I like the  
22 frame that we're developing again, the socio-

1 ecological model. But if our premise is that  
2 inequity is based, in part, on structural reasons,  
3 then I think thinking about advocacy at all those  
4 levels, so advocacy for the individual patient and  
5 the patient's needs, the linkages, what's missing  
6 in the community that they actually need: is it  
7 housing, it is transportation? So at that  
8 individual clinical level, but I think also at the  
9 provider level of is it a school district, is it  
10 another provider that's not providing culturally  
11 competent care that, as a payer, you could do  
12 something about.

13 And then ultimately back to Emilio's  
14 point, you can go all the way up to are you  
15 advocating for health insurance for people or for  
16 Medicaid expansion in your particular state?  
17 Again, it becomes very political, but if that's  
18 where the financing is going to happen, then  
19 that's an option that would actually address some  
20 of the inequities for folks who are uninsured or  
21 who don't have access.

22 So I think we can also think about the



1 policy and advocacy embedded in the various  
2 places. I think it belongs in this commitment to  
3 equity but just to flesh out that that might be  
4 how we -- and then figuring out what the measures  
5 are and how to evaluate that would be the next  
6 step.

7 CO-CHAIR PONCE: Great. Thank you.  
8 I'm going to go to Bob, but, for those on the  
9 phone, I'm going to call out folks on the phone  
10 after Bob's comments.

11 MEMBER RAUNER: I'm thinking kind of  
12 like something that could specifically add to the  
13 report to Medicare, so it could create something  
14 to literally address the disparities. So for  
15 example, MIPS, UDS, FQHCs already have measures  
16 for cancer, for example, one of our domains,  
17 breast, cervical colon, HPV vaccination, depending  
18 on which program you're in. But CMS has nothing  
19 specifically to address disparities within those  
20 programs, so why not add it?

21 So for example, there's a shared  
22 decision model grant that's sort of like an add-on

1       that an ACO could do right now. Why not create a  
2       similar kind of a grant-funded or incentive  
3       program because Medicare doesn't have the data,  
4       but I have it within our EHRs, actually. I can  
5       add to the colon cancer screening data, stratify  
6       it based on race, ethnicity, language preference,  
7       so why not create a grant incentive program, you  
8       know, some type of a model. Then they actually  
9       literally create the incentives for a provider to  
10      address these disparities, they give some  
11      examples. These straw domains could be strategies  
12      that you would write in the RFA. For example,  
13      they could be things that you could use to lower  
14      those disparities, and that will be something very  
15      specific and actionable for an FQHC or an ACO to  
16      actually start doing something to reduce  
17      disparities using the measurements that are  
18      already being used by MSSP. That's where I think  
19      a lot of these domains are already are broad  
20      measures, they're just not stratified, but  
21      Medicare could be and Medicaid could create  
22      incentives for us to specifically go after these

1 and bring that into the accountability. So my ACO  
2 or Nancy's ACO could really start doing these and  
3 having some incentives to build the infrastructure  
4 to do some of this stuff.

5 CO-CHAIR PONCE: Great. Thank you.  
6 For those on the phone, I think, Dave, do you have  
7 any comments?

8 MEMBER NERENZ: Sorry. I had to get  
9 off mute. I don't think I have anything very much  
10 to add beyond the comment I made a while ago. I'm  
11 still looking for ways to link these concepts and  
12 related measures to entities through other than  
13 healthcare providers. And, you know, a lot of the  
14 comments being made since I was live a few minutes  
15 ago, I think it would still emphasize the role of  
16 healthcare providers and getting into some of  
17 these areas. So I'm still questioning or  
18 struggling a little bit to figure out how CMS  
19 specifically would bring measures and incentives  
20 in some of these domains to life for entities,  
21 other than the healthcare providers, that they  
22 pay.

1                   So for example, if we looked at one of  
2                   these and said, well, you know, we're going to  
3                   follow the socio-ecological model and say that,  
4                   you know, the actor, if the essential accountable  
5                   entity for one of these things is, most  
6                   appropriately, the county health department.  
7                   Okay. We're going to talk about measures then of  
8                   how well the county health department does. I'm  
9                   still struggling for what do NQF and CMS do with  
10                  that?

11                  So I know I'm kicking a dead horse  
12                  here, but that's still what's in my mind.

13                  CO-CHAIR PONCE: That's a good comment.  
14                  Yolanda, do you have any comments?

15                  MEMBER OGBOLU: Thank you. So I agree  
16                  with much of what people have said already, and  
17                  I'm happy to hear this discussion of kind of  
18                  actual implementation, how is it going to happen,  
19                  how are we going to push anything forward by the  
20                  measures or whatever this process we are  
21                  addressing. And to Helen's comment about being a  
22                  roadmap and then maybe we could think about what

1 it would take for people to get to toll one, toll  
2 two, toll three. So it sounds like the  
3 conversation kind of bringing up good ideas about  
4 how we could do that, so it's the how piece. I'm  
5 very excited about that.

6 CO-CHAIR PONCE: Thank you. Thanks for  
7 your excitement. I believe Ron is not joining us;  
8 is that right? All right. So let's go to  
9 Eduardo, then Kevin.

10 MEMBER SANCHEZ: Reflecting on Bob's  
11 comments and Dave's comments on the phone, as Bob  
12 was talking about, he was talking specifically  
13 about cancer screening as an example. And not  
14 wanting to get into the weeds but using this as an  
15 example, a further example of what he's talking  
16 about, that there are measures out there about  
17 how, in the face of a clinical service, how one  
18 goes about engaging at a community level to  
19 mobilize people to get that done.

20 If you're trying to improve colorectal  
21 cancer screening and the issue is that people are  
22 scared of or have certain attitudes about

1 colorectal cancer screening, how you go about  
2 addressing that could include as a very specific  
3 example enlisting barbers to talk to their clients  
4 about the importance of colorectal cancer  
5 screening or hypertension screening, both of which  
6 there's a body of evidence around.

7 And so back to the question earlier  
8 about how do you hold the health department  
9 accountable, you don't necessarily hold the health  
10 department accountable except for partnering with  
11 them as an example to help in the recruitment and  
12 oversight of the barber community health worker  
13 cohort in the interest of that broader issue.

14 And so the accountability, as I think  
15 about it, can be thought of a couple of ways. It  
16 doesn't have to be everything that the health  
17 department does, but, as it relates to the domains  
18 that we're coming up with, what are the pieces  
19 that link back. I think that then makes it  
20 something that CMS can get its arms around because  
21 then that's about a suite of services that are  
22 trying to accomplish the objectives of CMS up to

1 and including closing disparities. And while  
2 barbers are not going to be the selling point for  
3 me on why I should get colorectal cancer screening  
4 or hypertension, only because I don't need to be  
5 convinced, I'm already sold, that might be a  
6 strategy that makes a lot of sense. And I use  
7 that very, very specific example to say there's a  
8 body of evidence out there about the things that  
9 do make a difference, and we don't necessarily  
10 need to categorize them or catalog them, but we  
11 should at least speak to the use of evidence-based  
12 community-enabling services that might link to the  
13 very clinically-centered things that CMS thinks  
14 are important.

15 So I think that adds a little bit to  
16 what both Dave and Bob were talking about earlier.

17 CO-CHAIR PONCE: Sure. Susannah. Is  
18 this on Eduardo's point? Okay. So Susannah  
19 first, and then Sarah, and then Kevin.

20 MEMBER BERNHEIM: So I just want to  
21 make sure I understood what you just said, which  
22 I think I did, which is that if you held the

1 public health department or the local ACO  
2 accountable for disparities in colorectal cancer  
3 screening, part of the evidence you would use for  
4 having that be a measure is that there are  
5 interventions that work. So you're not holding  
6 them accountable for the intervention, you're  
7 holding them accountable for the disparity with  
8 the evidence that there are interventions. Is  
9 that your point? I'm trying to imagine the  
10 measure.

11 MEMBER SANCHEZ: No. Actually, I would  
12 say the accountability is with that person or that  
13 entity that's been given the responsibility for  
14 overseeing the health of a population. So it  
15 could be the ACO. It could be any number of  
16 entities.

17 That ACO then has the knowledge of what  
18 is the menu of things that might work, and one  
19 would at least believe that that ACO would then  
20 put to use those things that makes sense in its  
21 community, which might include partnering with a  
22 health department or actually any other non-



1       profit. I use the health department. It doesn't  
2       have to be the health department. It might be an  
3       organization that calls itself the community  
4       health worker employment agency, and you contract  
5       with them, they're held responsible for their  
6       piece, but the accountable care organization is  
7       the one that's ultimately held responsible for  
8       closing the gap with all the different pieces that  
9       you have to put together to close that gap because  
10      even if the barber, if the barber convinces people  
11      they need their colorectal cancer screening and  
12      people line up and there's nowhere to get the  
13      screening, guess what? The rate doesn't change.  
14      You just activated people and you motivated them  
15      to do something, but you didn't deliver on the  
16      execution side. So the accountable care  
17      organization ought to be responsible for all the  
18      pieces.

19                   MEMBER BERNHEIM: I think that's  
20      actually what I was saying, but I understood.

21                   CO-CHAIR PONCE: Yes. And Sarah?

22                   MEMBER SCHOLLE: Just so I could add on

1 to that because in a measurement framework, then  
2 what are we measuring, okay? So are we measuring  
3 just is the gap closing and saying you're  
4 responsible for closing the gap, or are we also  
5 measuring whether the organization has structures  
6 in place for those community linkages? Do they  
7 have structures in place to know where the gaps  
8 are? Do they have structures in place that get at  
9 many of the topics that we've looked at, these  
10 capabilities? Because you might not be able to,  
11 first of all, you won't be able to see whether  
12 that gap is closing. It takes you some time for  
13 that to close, right? And so one way of thinking  
14 about this is to look at the way that the program,  
15 even the MIPS program is set up. Right now, the  
16 MIPS payment incentives say some of what we're  
17 going to pay you on is how you're organized, what  
18 systems you have in place, and some of what we're  
19 going to pay you on is actual achievement on  
20 quality measures. And so you could think about  
21 that, and by including some structural measures  
22 that get at how you're organized or what, you

1 know, what data sources you use, those things can  
2 serve as measures, you know, part of a measure's  
3 roadmap that people could demonstrate in the  
4 shorter term before they actually get to the  
5 reductions in disparity.

6 But when we start to say what are those  
7 things that everybody, what are those structures  
8 that people have to have in place, then that's  
9 where we get to the evidence about, well, what  
10 does that mean and how do you define it and how do  
11 you document that it's really in place? And we've  
12 had a fair amount of experience looking at trying  
13 to operationalize some of those concepts, and it's  
14 a little bit challenging and it also, the more you  
15 define what that looks like, the more you take  
16 away the flexibility of organizations to be  
17 creative about how they approach the disparities  
18 issues. So it's really a balance about where you  
19 think about your measurement.

20 And while we're on this, so, you know,  
21 when I think about this issue, I actually think  
22 the structural measures are really important

1 because you want to see that there are some  
2 systems in place. There's, you know, some  
3 engagement of the community in their quality  
4 improvement activities, that there's some data  
5 collection processes that are real and complete  
6 and, you know, focusing on understanding the  
7 network and community linkages. But we fight. We  
8 have a number of arguments about how far we should  
9 go and what documentation is sufficient on how to  
10 define those structures.

11 And one thing, so I actually like the  
12 idea of looking at structures and then saying  
13 what's the outcome we're getting to and measuring  
14 the outcome. One piece that I think is really  
15 important is to think about the data sources for  
16 looking at that outcome or process, and it's  
17 inviting to look at measures that already exist,  
18 like the measures that are in the ACO program and  
19 in the MIPS program, because they're aligned.

20 But the measures that we have for  
21 looking at individuals' experiences of care may be  
22 another opportunity to think about this. And

1       there's probably, there are way more items and  
2       tools available than are commonly used to capture  
3       experiences of care that get at things around  
4       cultural competence and literacy, and there are  
5       actually other tools that can be used to capture  
6       perspectives of individuals that are part of a  
7       team about how well the organization is really  
8       committed to these goals that have not been used.  
9       And that's another opportunity to think about as  
10      a data source for understanding something in  
11      between whether the structure is in place and  
12      whether the outcomes are achieved.

13               CO-CHAIR PONCE:  Thanks, Sarah.  That  
14      was very helpful.  We have Karen joining us in a  
15      few minutes at 10:45.  So if, Kevin, you would  
16      like to give your remarks now very quickly, or we  
17      can also wait --

18               MEMBER FISCELLA:  Yes, I can be very  
19      quick.  I realize that I probably undersold the  
20      value-based design a bit because, as I started to  
21      think about it, I realized, of course, the ACA has  
22      value-based design built into it.  I don't know if

1       it's really called that, but that's what it is.  
2       And it starts, of course, with essential benefits,  
3       which was our, you know, there was a huge  
4       political battle over that. But it has to start  
5       with what's going to be covered.

6               But then the second piece that really  
7       is truly value-based design is coverage of all  
8       preventive services that get an A or a B from the  
9       U.S. Preventive Services Task Force, and that's an  
10      example of value-based design applied to  
11      preventive services.

12             You know, I believe CMS has been  
13      looking at the issue, at least in the past, on  
14      value-based design regarding medication coverage.  
15      You know, certainly, we now have this crazy  
16      doughnut hole, which has gotten a little bit  
17      smaller but it still exists, so people could be on  
18      an essential medication and suddenly their liable  
19      for the whole shebang. Wouldn't it make a lot  
20      more sense to identify what the evidence-base  
21      medications are and adjust the co-payments  
22      accordingly?

1                   You know, it obviously is a rational  
2                   approach, and really I think the biggest obstacles  
3                   are probably, you know, political and market  
4                   issues, rather than really the idea itself. But  
5                   I think it really does have clear impact on the  
6                   issue of cost. As Emilio said, that's sort of the  
7                   elephant in the room that we're all facing. And  
8                   I think figuring out at least how to design these  
9                   plans better that put value at the forefront will  
10                  help improve.

11                 CO-CHAIR PONCE: Thank you. And I also  
12                 want to note that Christie raised this yesterday,  
13                 as well. Apologies, Philip and Emilio. Can we  
14                 get back to you afterwards? I'm going to turn it  
15                 to Erin.

16                 MS. O'ROURKE: Great. So I just want  
17                 to clarify our next steps before we transition to  
18                 our conversation on some of the data challenges  
19                 that have started to be a predominant theme  
20                 through our conversation.

21                 So I think this was a great  
22                 conversation. Drew and I were emailing furiously

1       about our next steps. So I think we're going to  
2       make another attempt to take your comments, revise  
3       the domains and sub-domains. We were also  
4       thinking it will be valuable to start to show you  
5       through homework what the rest of the roadmap is  
6       going to look like so you can see that we're not  
7       going to lose some of these themes that might not  
8       necessarily be an explicit measurement domain but  
9       have an important link to some of the other pieces  
10      of the roadmap, like Helen was saying. This is  
11      one piece of the puzzle that we want to put  
12      together as a plan for how we can reduce  
13      disparities. I think Marshall was very clear and  
14      Ninez, as well, when they signed on to be co-  
15      chairs that we don't want to do just another list  
16      of measures and gaps but rather to draw that  
17      connection to some of the other levers that we  
18      have at our disposal and think about, Kevin, as  
19      you were saying, the connections to value-based  
20      payment, what we can do, Helen's points about  
21      getting ahead of ACO and population-based  
22      payments.



1                   So if we could put all of these great  
2 thoughts together and show you an early at least  
3 outline for the roadmap, maybe it would make the  
4 picture start to emerge and let people see where  
5 all of these rich comments could hang on, what  
6 this roadmap would look like. So I think we will  
7 start to do that and get back to you probably in  
8 a few weeks with homework, maybe specifically  
9 asking you to finalize the domains but then  
10 getting some preliminary thoughts on what you  
11 think about the direction of the roadmap so that  
12 we can hit the ground running when we come back  
13 together in June.

14                   So I think with that why don't we  
15 transition to start to dive deep into some of the  
16 data issues. I'd like to introduce Karen Joynt  
17 and her team from the Office of the Assistant  
18 Secretary for Planning and Evaluation. And Sarah  
19 is also going to be sharing some of the work that  
20 NCQA is doing around data concerns.

21                   So, Karen, are you on the line?

22                   DR. JOYNT: I am. Good morning,

1 everyone.

2 CO-CHAIR PONCE: Good morning.

3 DR. JOYNT: I'm also joined by Rachael  
4 Zuckerman and Robin Yabroff who are also on the  
5 line who are the other leaders of the team that's  
6 been working on this over at ASPE.

7 CO-CHAIR PONCE: Sorry, Karen. This is  
8 Ninez. Everybody says good morning, but their  
9 mikes are off. But, apparently, your mike is a  
10 little weak. Could you talk louder, please? Thank  
11 you.

12 DR. JOYNT: I sure can. Is that  
13 better?

14 CO-CHAIR PONCE: Sort of.

15 DR. JOYNT: Let's see. I'm about as  
16 close to the phone as I --

17 CO-CHAIR PONCE: That's better, that's  
18 better.

19 DR. JOYNT: Better? Okay. We'll stick  
20 with that then. Okay. Should we just plan to go  
21 through our slides here then? I'll take that as  
22 a yes.

1 CO-CHAIR PONCE: Yes, yes.

2 DR. JOYNT: Okay. So we're very  
3 excited to be joining you all today and are really  
4 hoping, I think, to learn from you as much as we  
5 present anything. As many of you know, we've been  
6 involved in a series of reports to Congress  
7 examining the issue of social risk or  
8 socioeconomic status and Medicare payment policy.

9 Our charge in the first report, which  
10 we've presented previously, was really to take  
11 existing measures of social risk, the things that  
12 we had access to in existing data for a broad  
13 group of Medicare beneficiaries and look at the  
14 relationships between those items and outcomes and  
15 performance under the measures and programs  
16 currently in use in Medicare. And that was the  
17 topic of our first report and I think, for us, was  
18 a learning experience in a couple of ways.

19 First, we learned that there are  
20 pervasive disparities across many, many measures  
21 and many different parameters of social risk.  
22 And, second, we learned that we have a long way to

1 go in terms of data on social risk.

2 Now, Congress, in its warped-  
3 sightedness -- is that a word -- actually  
4 anticipated this. And in the charge that we  
5 received in the initial impact statute, we were  
6 actually asked to complete two separate reports,  
7 the first being the one that I just mentioned and  
8 the second being one that specifically, in which  
9 we're specifically asked to take new data sources  
10 into account.

11 So that's the road down which we're  
12 embarking now, and that's one reason why we're  
13 excited to be able to join this conversation with  
14 you and learn from the experts about how we might  
15 think about data. So we'll just, in a few slides  
16 here, share sort of the framework that we're  
17 working from and then very much look forward to  
18 your feedback on how we should expand our thinking  
19 about that.

20 So I'll turn over to Rachael and Robin  
21 to go through our little baby set of slides here,  
22 and then we'll look forward to discussion.

1 DR. ZUCKERMAN: Yes. Thanks, Karen.  
2 So working, thinking about how we did this, Karen  
3 talked about the report that ASPE produced, and  
4 then separately, or in conjunction is maybe a  
5 better way of thinking about it, we asked the  
6 National Academies of Medicine to do a series of  
7 five reports on social risk factors in Medicare  
8 payment.

9 So the first of these is what you see  
10 on this slide where they identified five main  
11 social risk factors. So the socioeconomic  
12 position, race, ethnicity, and cultural context,  
13 which together are a risk factor, gender, social  
14 relationships, and residential and community  
15 context. And each of those has a number of  
16 components that build into them.

17 And they also pulled out health  
18 literacy, mostly for our benefit because it was  
19 listed in the law. And so they showed us the  
20 relationship between that, and what we don't have  
21 on this slide but, if you're interested in pulling  
22 up the report, they actually made a conceptual

1 framework to sort of work through how each of  
2 these risk factors plays into individuals'  
3 interaction with the health system and then health  
4 outcomes.

5           So we took that information, and we  
6 went -- we don't have the slides, do we? So can  
7 we go to the next slide? Let's see. And sort of  
8 thought about, okay, now that we have identified  
9 social risk factors, how do we measure it? And  
10 these are a number of questions that are based on  
11 our work and the National Academies of Medicine,  
12 and we're hoping that part of what you guys can  
13 help us with today is thinking about them.

14           So which social risk factors are most  
15 important to capture of those five factors and  
16 then of the individual measures that comprise each  
17 of those five social risk factors? Which of them  
18 have validated measures? Because it's always  
19 harder to measure things when you haven't figured  
20 out how to do it yet. Which social risk factors  
21 are stable over time? And this really leads to  
22 more of a data collection issue. Can it be a one-

1 time data collection, or do we need to do it  
2 repeatedly over time? What data are currently  
3 available to measure social risk factors? Again,  
4 if data is already available, there's an ease with  
5 that. And then, finally, if it's not available,  
6 what's the burden of new data collection and  
7 really for whom? Is it on beneficiaries,  
8 providers, the Medicare program, or some  
9 combination of those three groups?

10 So those are sort of what we're  
11 thinking about now. And I'm going to turn it over  
12 to Robin for the last couple of slides.

13 DR. YABROFF: Great. Thanks, Rachael.  
14 You can show the next slide. The National  
15 Academies did some of this work in thinking about  
16 some of those questions that Rachael posed for us,  
17 and I'm going to bring you briefly to this slide.  
18 So in the left most column are a list of the  
19 different social risk factors, and then the other  
20 columns provide an indication about data  
21 availability, and they've used a nice color-coding  
22 scheme. So the green indicates available for use

1 now, the light green is available for use now for  
2 some outcomes but additional research is needed.  
3 The light red is not sufficiently available now  
4 and research is needed for improved future use,  
5 and then the dark red where research is needed to  
6 better understand the relationship with healthcare  
7 outcomes and how best to collect those data.

8 So I'm going to walk you through a  
9 couple of examples to help to orient a little bit  
10 more. If you look under socioeconomic position,  
11 which is abbreviated as SEP, you'll see in dual  
12 eligibility that is categorized as a one,  
13 available for use now, because that is available  
14 in enrollment data, in the Medicare claims  
15 enrollment data.

16 Other factors, like acculturation, is  
17 a dark red, so that is research is needed to  
18 better understand relationship with healthcare  
19 outcomes and how best to collect those data.  
20 Other factors like marital and partnership status,  
21 living alone, social support, those are more in  
22 the middle where additional work is needed, so not



1 quite available for work now but not no or little  
2 information available.

3 So if I can move on to the next slide,  
4 some of the data to consider for some of these  
5 social risk measures are listed here. So,  
6 obviously, claims and enrollment data, provider  
7 and plan reported data from either administrative  
8 data or EHR-derived data, individual reported data  
9 most commonly from survey data. So we've  
10 categorized these as broad, something like census  
11 data. Medicare Current Beneficiary Survey data  
12 where we have quite a bit of information but only  
13 on a relatively small number of people and then  
14 more targeted, which has a larger number of people  
15 potentially and also more detailed questions.

16 Other types of data that are not listed  
17 here, things like area-level measures from the  
18 American Community survey, some of those  
19 neighborhood community context sorts of measures  
20 would be best measured with other area-level data.  
21 And then, of course, we really would like to have  
22 some of your input about other types of data that

1 we may not have considered.

2 So with that, if we can move on to the  
3 next slide, I really want to open this up for  
4 discussion and questions, and I also want to note  
5 that we have a mailbox. If you have ideas later  
6 after we're done today or at some other time,  
7 please feel free to contact us, and we will, I'll  
8 get this message and any of us can respond. So  
9 with that, I'd like to open up the discussion and  
10 thanks for your attention so far.

11 CO-CHAIR PONCE: Thanks very much. I  
12 heard a specific ask about data sources. Could  
13 you also formulate what other questions you have  
14 for the committee here?

15 DR. JOYNT: Well, if you wouldn't mind  
16 moving back to, I think it was the third slide.  
17 One more before that. There. You know, I think  
18 we are sort of grappling with some of these  
19 questions now, but if you have, if you have  
20 thoughts or ideas related to some of these, you  
21 know, which social risk factors are most  
22 important, validated measures, and burden of new

1 data collection, I think that would be a really  
2 important topic for conversation.

3 CO-CHAIR PONCE: Okay, great. You have  
4 an audience here. Nancy Garrett and then Bob  
5 Rauner. Oh, oh, sorry.

6 MS. O'ROURKE: Sarah, what would work  
7 better? Do you want to present and then we have  
8 a more general conversation on data or --

9 MEMBER SCHOLLE: I think it might be  
10 helpful because it could provide a little bit of  
11 context of the existing data.

12 CO-CHAIR PONCE: Okay. So we're going  
13 to hold off on the questions and have Sarah  
14 present next.

15 MEMBER SCHOLLE: Good morning. Erin  
16 had just asked me to present a little bit about  
17 the availability of data on social risk that we  
18 know about from our programs and some research  
19 that we have underway. So next slide.

20 So just the key takeaways. We're  
21 seeing more complete data at healthcare system and  
22 practice level than in health plans, but we're

1     seeing tremendous variation in how patients are  
2     asked about social risk. So probably not news to  
3     anybody.

4             We can go to the next slide. Just to  
5     give you some information -- sorry. These slides  
6     aren't projecting well. We have a paper that just  
7     came out in Health Affairs this month that  
8     provided information on what health plans report  
9     to NCQA about race, ethnicity, and language needs  
10    of their membership. And so this is voluntary  
11    data, and I guess we probably should have changed  
12    the color. The green means they don't have data,  
13    and so the first, so what we've got is a series of  
14    columns or slides for commercial plans, Medicaid,  
15    commercial. The first five columns or bars,  
16    Medicaid is in the middle and Medicare is on the  
17    right side of your screen.

18            And I guess just to start with, you can  
19    see Medicare has less green. That's good. And  
20    what the blue means that there's complete data.  
21    So the blue, that's the percentage of plans  
22    reporting to NCQA who had complete data on race,

1 ethnicity, spoken language, written language,  
2 other language needs.

3 A couple of things. Commercial plans,  
4 this is not a big deal for commercial plans. This  
5 is voluntary reporting, so they don't have access  
6 or they don't report it. And even for Medicare  
7 and Medicaid where we would expect to have  
8 complete known information, they're not reporting  
9 it.

10 So this means it's really hard to do  
11 stratified reporting on measures if you don't have  
12 complete known information. And there's a big  
13 difference for language versus race/ethnicity. It  
14 has to do with which is the right category to use  
15 if you wanted to look at language needs.

16 Go to the next slide. Now, in our  
17 patient-centered medical home program, so  
18 currently 60,000 clinicians are recognized in  
19 NCQA's patients under medical home program. It's  
20 about not quite 20 percent of practicing primary  
21 care clinicians. And we do expect that practices  
22 have information on the diversity of their patient

1 population. You can see that most of them do.  
2 And a lot of this is aligned with the expectations  
3 for meaningful use.

4 There's a concern, and you can see so  
5 there's pretty good documentation of race, sex,  
6 ethnicity, preferred language in these practices.  
7 And even that we see practices starting to look at  
8 social risk, although there's tremendous  
9 variability in how they do that. We don't have  
10 any criteria that say do it this way or ask this  
11 question, and it's all over the map.

12 Health literacy assessment is less  
13 common. And even in the meaningful use  
14 requirements, I understand that there is a  
15 category of refused or unknown. And like in the  
16 health plan reporting, refused/unknown is not  
17 treated as missing, right? It's treated as  
18 refused or unknown. And that might present an out  
19 for organizations to say you don't have to tell me  
20 this, rather than a positive it's important for us  
21 to know. How this information gets rolled up when  
22 you think about health plan or population when you

1 might have competing or different results is  
2 unknown.

3 Go to the next slide. I just want to  
4 call out some information that we have a fellow.  
5 Keri Christensen is our first Phyllis Torda  
6 Quality fellow. She's been working on the topic  
7 of social risk, and she's done a really nice  
8 review of 15 initiatives across the country that  
9 are looking, obtaining self-reported information  
10 on socioeconomic status and other categories of  
11 social risk. She's got a report that she's  
12 developing for publication where she's looked at  
13 how many of those initiatives are capturing data  
14 on different parts of the NAM framework. And so  
15 what her data show is that those organizations are  
16 most often asking questions about topics that are  
17 in the SES category or the socioeconomic position  
18 and residential context criteria.

19 You can go to the next slide. You can  
20 see there, so this is all self-reported  
21 information.

22 Go to the next slide. But it's all

1 over the map the kinds of questions that are being  
2 used. And I guess you probably can't see the  
3 questions that are here, but even on something  
4 like transportation there's a lot of variability  
5 in the ways that organizations are asking these  
6 questions.

7 So I just wanted to -- I think that's  
8 my last slide. I just wanted to give you a little  
9 bit of context of what we're starting to see.  
10 And, Karen, we'd be happy to share more of the  
11 information from the details of this, if that  
12 would be helpful to you.

13 DR. JOYNT: That would be terrific.  
14 That's amazing work to have that kind of detail  
15 around the specific ways that some of these data  
16 are collected. Certainly the future of measure  
17 collection, I would presume, is, you know, through  
18 electronic capture and sharing of those types of  
19 data, but that raises a host of questions going  
20 all the way from collection, as you point out.  
21 How are we even asking these questions and is that  
22 consistent, and then how can we share it in a way



1       that's respectful of privacy? And then maybe most  
2       fundamentally difficult, how do we use those data,  
3       and are they most appropriate for helping us  
4       target interventions or for thinking about  
5       quality, or, you know, how do we even incorporate  
6       these data, presuming that we can get them in a  
7       consistent way, into how we think about policy.

8               MS. O'ROURKE: So would it be helpful  
9       if we put Karen's questions back up just to kick  
10      off conversation and go from there? I think we'd  
11      also just like to tack on if people could think  
12      about some of the data considerations that came up  
13      from our earlier conversations and how we might  
14      just start to collect some of that data. In  
15      particular, people suggested we need more  
16      information on adverse childhood experiences,  
17      things like cumulative allostatic load, and then,  
18      Lisa, starting to get to your point about the  
19      intersectionalities and this idea of, I'm blanking  
20      on the term that Ninez coins, but the cumulative  
21      structural disadvantages.

22             CO-CHAIR PONCE: Okay. Nancy, then

1 Bob. Nancy Garrett, then Bob Rauner.

2 MEMBER GARRETT: Hi. This is Nancy  
3 Garrett, and I am from Hennepin County Medical  
4 Center, which is a safety net in Minnesota. So,  
5 Karen, thank you so much for presenting this  
6 important work and for getting our input.

7 My first piece of input is kind of  
8 global, and it's around the domains themselves.  
9 So you have -- and I don't know if that's up for  
10 discussion or not, but I'll just give you my  
11 initial thought here. You have income as one of  
12 the categories. We have just finished a community  
13 assessment where we looked at all of the different  
14 needs that our community has as they interact with  
15 the healthcare system, and the two domains that  
16 are really coming up as the most important for our  
17 safety net population are housing or housing  
18 stability or homelessness and food and security.

19 And so the way we are planning to  
20 approach that, we're really trying to coalesce  
21 around the IOM recommendations for electronic  
22 capture of social needs, and they have a question

1 on general income instability or insecurity, and  
2 we're going to have some drill-down questions from  
3 that on housing and food and security, and we're  
4 going to start with the food and security  
5 question.

6 So those two dimensions are just so  
7 important, and they don't necessarily correlate  
8 with income. I mean, you can be retired and have  
9 a low income and be absolutely good in terms of  
10 food and housing, or you can -- you know, there's  
11 so many variations. But really those are some  
12 basic needs that if you can't meet those needs,  
13 it's very hard to maintain your health. And so I  
14 just think those are really important.

15 In terms of the data collection, it's  
16 really important, I think, to watch the  
17 Accountable Health Communities' project. In that  
18 project, assuming that that still continues, there  
19 is a requirement that all of the providers who  
20 participate in it collect social determinants of  
21 health, that they screen their whole population,  
22 and that they use a standard questionnaire that is

1 developed as part of that project.

2 That questionnaire, I just pinged Alex  
3 yesterday, it sounds like it will be released in  
4 a month or so. But in a sense, that's going to  
5 become a de facto standard overnight because if  
6 the participants in the model, the goal is to have  
7 over three million patients screened annually for  
8 three to five years on those questions.

9 And so we are really watching that. We  
10 applied to participate in the model, but, even if  
11 we don't, we want to use those same questions  
12 because then we get comparability across providers  
13 and we start to have some standards. So I think  
14 it's really important that we all watch that.

15 And then just in terms of other data  
16 sources to start to think about, we have done some  
17 work linking data from social services with  
18 healthcare. And, in fact, in Minnesota, we passed  
19 a law that allows that kind of data sharing. And  
20 I think there's a lot of information in the social  
21 services world, for example from HUD on housing,  
22 and I wonder if there are ways to use some of that

1 data in a more national scale with Medicare that  
2 might be possible.

3 And then Christie would be the expert  
4 on this, but commercial data sources where they  
5 aggregate data together based on credit card,  
6 magazine subscriptions, etcetera. I know you've  
7 done some work linking that to kind of data. And  
8 I wonder if there's some possibilities there.

9 We worry a little bit about what is  
10 the, is the digital footprint that people leave  
11 equal across socioeconomic status levels? And so  
12 is it really going to be an accurate depiction of  
13 a population, but I think there is increasing  
14 research on that.

15 CO-CHAIR PONCE: Thanks, Nancy. Bob?

16 MEMBER RAUNER: Back to filling in the  
17 gaps of missing data, a lot of these things would  
18 be readily capturable within a clinician's EHR The  
19 biggest limitation that we have on the provider  
20 level is that the EHRs have very rudimentary  
21 abilities to do any reporting on the data within  
22 the EHR. So for example, you would think an

1 advanced EHR would be able to pull up my list of  
2 a 1500-patient panel, give me a list of the  
3 diabetics, how many are out of control, and give  
4 me that list. Almost none of the EHRs actually  
5 can do that. It should have been one of the most  
6 basic population abilities of an EHR, and I think  
7 that's the single biggest failing of the ONC the  
8 last five years is they didn't do that.

9 A specific recommendation to CMS could  
10 be that the ONC certification means the ability to  
11 do that but not only do that but do that based on  
12 stratifying the socio-demographic risk factors.  
13 So for example, I could pull up my list of  
14 diabetics who are Hispanic and how many are out of  
15 control. That would be one of the biggest things  
16 that could help us in the provider level make huge  
17 strides on some of this stuff, but our EHRs are  
18 really, literally have to hire someone to come and  
19 run reports or databases to pull any of this  
20 information out of your EHR. It's in there. It's  
21 in the underlying database structure, but none of  
22 them have reporting abilities to do this stuff.

1 And provider levels or an FQHC, if they could pull  
2 this stuff out easily, you could really go after  
3 this stuff. And so it's something we could really  
4 tell, you know, ONC and CMS that an EHR has to be  
5 able to add these measures and allow the providers  
6 to pull this stuff, so they can act on it.

7 CO-CHAIR PONCE: Philip Alberti and  
8 then Emilio, Christie, and then Lisa.

9 MEMBER ALBERTI: Thank you for the  
10 presentation and for all of the work that have  
11 gone into these reports. They're fantastic.

12 So in terms of data sources, I think my  
13 first comment is the importance of measuring the  
14 impact of these social risk factors at both the  
15 individual and the community level. And so in  
16 terms of an individual's industry or occupation or  
17 wealth or social isolation are certainly  
18 important, but it is equally important the  
19 community context and the community's level of  
20 income and wealth and social isolation.

21 So I think data sources for those  
22 social risk factors are the aggregate, looking at

1 some of the CDC data collections. I know there  
2 are some communities in New York City I'm most  
3 familiar with that actually can drill down to the  
4 neighborhood level, very specific kind of  
5 community neighborhood-defined neighborhoods on  
6 those variables, and I think that would be an  
7 important addition to our work, particularly as it  
8 relates to the SDS trial period.

9 And so I do have a question about that.  
10 Is this an appropriate moment to kick that --  
11 excellent. So most of the, I noted there were ten  
12 variables in the dark green or light green boxes  
13 that are ripe for inclusion in our models and our  
14 tests to some, to some degree. Most, if not all,  
15 of the measure tests in the period that I've seen  
16 have drawn on one dark green box, dual eligibility  
17 status, and one light green box for  
18 race/ethnicity, kind of to the exclusion of the  
19 other eight.

20 So I guess my question is, given this  
21 report, this series of reports, and data  
22 availability, what's the expectation given kind of



1 the sunset of the trial period that the general  
2 kind of lack of use of these available data,  
3 according to the reports?

4 DR. BURSTIN: It's a great question,  
5 Philip, and we'll be coming to it shortly as we  
6 talk about the evaluation of the trial period and  
7 what are the next trial period. I mean, there are  
8 three options. It could sunset, it could persist  
9 as a trial with additional rigor, or it could move  
10 into permanent policy with additional work around  
11 it. So those are our three options we'll come to.

12 I guess I'd actually have a question  
13 for Karen in particular and the ASPE team. You  
14 know, much of what they picked up on initially to  
15 do the ASPE reports were those data because  
16 they're available, and their next reports are all  
17 about looking at those analyses for future data.

18 As you look at the NAM report, Karen,  
19 how many of those measures listed as being sort of  
20 potentially available or on the horizon could you  
21 realistically see getting kind of folded in  
22 particularly to the kind of CMS data that's

1 typically used by Susannah and others to do some  
2 of the outcome measures? Any thoughts on that,  
3 Karen?

4 DR. JOYNT: Yes, that's a great  
5 question. I think the difficulty is really the  
6 breadth of the data. You know, we're going to  
7 through the process now of digging into some of  
8 these data sources where you can access some of  
9 the risk factors that we hadn't been able to  
10 before, but we only have them on a very small  
11 sample of patients. So they're useful in terms of  
12 elucidating relationships. They're not so useful  
13 in terms of thinking about how they could impact  
14 measures. If you only have them on 12,000 people  
15 or something like that, you know, you can't  
16 realistically get the broadest picture, especially  
17 when you're thinking about low volume providers  
18 and more rare social risk factors.

19 So I guess I don't see in the  
20 immediate, you know, like in the next few years  
21 that many of these things will be ready for prime  
22 time. One exception to that, actually, may be

1 some of the area stuff. Our difficulty in the  
2 first report, and if you look at the results of  
3 that report you see a lot of odds ratios of like  
4 1.01 for some of the area-level measures. And  
5 it's not that they're not important. It's that  
6 they weren't precise enough, so they tracked  
7 better with rural poverty than with urban poverty  
8 because the area that we used I think wasn't small  
9 enough to really get to some of the disparities  
10 that might be really important.

11 So that actually is more of a  
12 technology issue than a data availability issue.  
13 You just need to be able to drill down through  
14 geo-coding, as opposed to just ZIP codes.

15 Many of the other ones are just simply  
16 not available broadly enough currently to be able  
17 to be in the very near future integrated into  
18 measurement.

19 MEMBER ALBERTI: The question, the  
20 follow-up, is there a difference from our  
21 perspective in the oversight of this trial period  
22 between readiness for ability to be used tomorrow

1 and actual measures or ability to be used in an  
2 empirical test even if the end is not a national  
3 sample? Is there some use in thinking about the  
4 empirical testing of these with the full  
5 availability of what data are available for 12,000  
6 cases or 15,000 cases that might actually shed  
7 some light on the relationship going forward?

8 DR. BURSTIN: And, actually, the next  
9 item we'll talk about among the set of unresolved  
10 issues for the trial period is this question of we  
11 were asked specifically to ask this committee to  
12 help us think through hospital and neighborhood,  
13 hospital and community-level factors, and that's  
14 a really good question to tee up as part of that  
15 discussion. And, Karen and the ASPE folks, you're  
16 more than welcome to stay on for part of that  
17 discussion if it would be useful as we go to that  
18 after lunch.

19 CO-CHAIR PONCE: And before I go to  
20 what's on the queue, I think that is an important  
21 question. You know, I run a survey in California  
22 called the California Health Interview Survey

1 where we have a lot of these social factors, and  
2 we're also part of the National Network of State  
3 and Local Surveys, so issues like a question bank,  
4 you know, having the questions being very similar,  
5 is discussed voraciously amongst this group, and  
6 I think we also, another idea is, you know, we  
7 can't fund the survey to get the granularity of  
8 the ZIP codes the census tracks, and so we do  
9 small area estimation at the ZIP code level, but  
10 we can actually do it at the census track level.  
11 And that's the strategy that CDC is using for the  
12 500 Cities Project, as well.

13 So I think looking at the  
14 relationships, but I think relationships do  
15 matter, even though it's a smaller jurisdiction,  
16 to understand then how social factors really come  
17 into play.

18 So I believe it was, I know Kevin was  
19 -- so Christie, Lisa, and then Kevin, and then  
20 Sarah.

21 MEMBER TEIGLAND: So we have done some  
22 looking at the EHRs, and you would hope that the

1 EHRs would have some promise in having some of  
2 this data. In fact, they tell you that they do.  
3 So Inovalon has relationships with five big EHRs  
4 that are in a lot of the Medicare plans, the big,  
5 big health plans, Allscripts, NextGen, Greenway,  
6 and we've taken a look at their data. They said,  
7 oh, yes, we have it, and it's, you know, 88  
8 percent or 90 percent or 95 percent populated.  
9 And, indeed, when we look at it, it's populated  
10 with unknown or declined. You know, if it's 95-  
11 percent populated, 90 percent of it will be  
12 unknown or declined. And then a lot of it's  
13 missing, too. Some of it is just missing. But a  
14 lot of it does have it checked as  
15 unknown/declined.

16 So we found that we could probably only  
17 pick up five percent more of this socioeconomic  
18 data. From all of those EHRs that we have  
19 relationships with, there's no useful data in  
20 them. Very, very disappointing.

21 One of the things we had done is linked  
22 to patient registries. So for example, we linked

1 our data the Cystic Fibrosis Foundation registry.  
2 And some of them have this kind of data, some of  
3 them don't, but when it's important to the  
4 disease, you know, the particular disease  
5 condition, they will have some of this data. So  
6 I just want to throw that out there as one option,  
7 as well. There's all these patient registries  
8 that -- and, of course, the benefit of us doing  
9 that is that we have more of the biometric data  
10 and all the kind of data, clinical data that's in  
11 those registries that are not in typical  
12 administrative claims data. So you can then  
13 actually look at utilization and outcomes and all  
14 those good things, so a win/win sort of  
15 relationship, I think, for organizations doing  
16 that.

17 So I will talk a little bit, just  
18 briefly describe the two sources of socioeconomic  
19 data that we have looked at that Nancy referred to  
20 that is at a very granular level, nine-digit ZIP  
21 code, there are 30 million data points. You can  
22 get it at the person level. For a large

1 percentage of the population they actually have  
2 this data at the patient level. That would  
3 require too many HIPAA, you know, rules for us.  
4 So we actually got it at the nine-digit ZIP code  
5 level. Average of five households. So, yes,  
6 highly predictive of patient health behaviors.

7           So we found that when we would do  
8 modeling of, say, measures like medication  
9 adherence or re-admissions where other studies  
10 that have used, as Karen just said, data that was  
11 not granular enough, yes, you're finding that dual  
12 status has an effect, but you're not finding that  
13 poverty, living in a high-poverty area, living,  
14 you know, what is the percent of home ownership in  
15 that area, are you living in a high-rise apartment  
16 complex or a suburban area or a rural area, the  
17 income and education obviously. Household size  
18 was a really important one, as well as marital  
19 status, that we found.

20           And we find some interesting things.  
21 I think I presented to you guys last year about  
22 medication adherence. So if you just use dual



1 status or low-income subsidy status, you find that  
2 duals are less likely to be adherent to  
3 medications. When you add income, poverty, living  
4 in poverty to that equation, the duals actually do  
5 better than those poor non-duals who are right on  
6 the cusp and don't have those extra supports that  
7 the dual-eligibles have.

8 So, yes, those variables are important  
9 beyond dual status. We have found that to be true  
10 when you use precise enough data.

11 The source that we use, Acxiom, is  
12 really not very expensive. In fact, the Pharmacy  
13 Quality Alliance, who has very little money, was  
14 able to purchase it for about the same amount of  
15 money we did. It's like \$20,000, two years of  
16 data, literally hundreds of variables. We got  
17 like 600 variables. They're very extensive. We  
18 can even test all of them. But, obviously, a  
19 small organization can't do that, but a community  
20 could, a health department could, a CMS possibly  
21 could. You know, there are some other  
22 organizations, Lexis-Nexis, that want hundreds of

1 thousands of dollars for their data.

2 So there's a wide disparity in terms of  
3 what it costs, but in terms of -- I mean, we've  
4 all been saying it's not cheap to collect this  
5 data. So to move us forward, there might be some  
6 potential for some, for using some of this data.  
7 At least it demonstrates that the evidence is  
8 there when you do use the granular enough level  
9 data, where you then get the data for real for  
10 every single day. Practical application is  
11 another story.

12 CO-CHAIR PONCE: Thanks, Christie.  
13 That's Christie from Avalere, Inovalon. Yes.  
14 Lisa Iezzoni.

15 MEMBER IEZZONI: Wow, that's so  
16 interesting. It's so much fun to have actual  
17 practical information. Thank you, Christie.  
18 First of all, gender is noted to be 100-percent  
19 collected, but I would suggest that it's probably  
20 not actually, given the way that people often,  
21 especially young populations nowadays think about  
22 gender. And this is going to be a big disparities

1 issue, especially if you're looking at healthcare  
2 for young people. So I would eliminate that 100  
3 percent gender is collected because it may not be  
4 collected the way that it needs to be to look at  
5 disparities for people who are trans and other  
6 gender identities. So we need to think about  
7 that.

8 CO-CHAIR PONCE: It's right here, but  
9 I think in Sarah's presentation it was --

10 MEMBER IEZZONI: Yes, in Sarah's  
11 presentation, it was listed as 100 percent.

12 MEMBER SCHOLLE: Right. Because it's  
13 the sex category from --

14 CO-CHAIR PONCE: It's sex versus gender  
15 identity and gender expression.

16 MEMBER IEZZONI: And that's all I'm  
17 saying is that male/female --

18 MEMBER SCHOLLE: And that's what the  
19 meaningful use requirement --

20 MEMBER IEZZONI: -- especially for some  
21 populations, it's not going to be sufficient. The  
22 second thing is I think that, and I say this with

1     some caution, especially as undocumented  
2     individuals in the United States are increasingly  
3     facing confrontations with ICE agents, that  
4     willingness to reveal Hispanic or other identities  
5     that might not, might suggest that they may be  
6     undocumented I think is going to increase. And  
7     I'm not sure how long this is going to be in  
8     place, how long these kind of concerns will  
9     happen, but I know that people who are thinking  
10    about the 2020 census are already worried about  
11    whether some populations are going to be  
12    undercounted because of concerns about ICE agents  
13    knocking on their doors. And so I think that  
14    that's going to be something that I'm not sure how  
15    we put that in the report for CMS, but I just want  
16    to raise the issue.

17               Another issue is that we recently have  
18    completed a very intensive effort to collect data  
19    from people with significant physical and mental  
20    health disabilities, and we have found people do  
21    not like using online data collection. They want  
22    to speak to a person. And so they really, like

1 five percent of people, and we had like 60-percent  
2 response rates on our surveys, including from  
3 homeless people. In fact, our homeless people had  
4 higher percentage response rates, but they wanted  
5 to speak to somebody. It was just that human  
6 connection, rather than going online. And so I  
7 think the increasing trends towards digital data  
8 collections are going to really leave out some  
9 populations.

10 And then, inevitably, I do have to  
11 mention that the NAM report did not include  
12 disability and disability measures are not part of  
13 meaningful use. There was the presentation that  
14 we had during our first meeting where the  
15 statement was made that it's too hard to collect  
16 disability, the disability community would push  
17 back and say, no, that's not true, we can at least  
18 start using the six questions that the Civil  
19 Rights Division has employed. And so I just want  
20 to make sure that in all these conversations about  
21 data, especially given our charge from CMS, that  
22 we do not forget disability. Thanks.

1 CO-CHAIR PONCE: Thank you, Lisa. I  
2 also note in this particular chart immigration is  
3 not on it, unless it's folded into acculturation  
4 perhaps. But, yes, the concern about whether we  
5 should ask it or not, I'm grappling with that  
6 right now.

7 DR. YABROFF: Hi, this is Robin Yabroff  
8 from ASPE, and I just want to interject quickly  
9 that the NAM report mentioned disabilities in  
10 medical risk.

11 MEMBER IEZZONI: And those of us who  
12 deal with disability feel that that's a very  
13 medicalized definition, and we think that that is  
14 not for what we're talking about here, which is  
15 disparities where stigmatization and social  
16 factors are affecting people's disparities, that  
17 the medicalization of disability is not something  
18 that we support.

19 DR. YABROFF: Okay. Thank you. I  
20 wanted to make sure that you knew that it was  
21 addressed at some place, even if it's --

22 MEMBER IEZZONI: I reviewed reports for

1 NAM and made many, many, many copious comments  
2 about that. However, at the end of the day, the  
3 medicalized people won over.

4 DR. YABROFF: Okay. Well, thank you.

5 DR. JOYNT: This is Karen. We're very  
6 glad to have your voice on that and hear you.  
7 We're doing some work trying to, trying to examine  
8 some metrics of ways to detect disability using  
9 other sources of data, claims and other things  
10 like that. But if you don't mind, we would love  
11 to follow-up with you at some point to learn more  
12 about that.

13 MEMBER IEZZONI: I would not mind.

14 CO-CHAIR PONCE: Thanks, Lisa. Kevin,  
15 then Philip, then Bob.

16 MEMBER FISCELLA: So these are really  
17 ideas for potential pilots to explore more and  
18 potentially CMS, you know, could do that. The  
19 first is use of the Z codes 55 to 65. And I could  
20 imagine where one could go through those codes and  
21 begin to say, okay, you know, we think that these  
22 are really important, could even affect the cost

1 of care, and, on a pilot basis, begin to look at  
2 incentivizing or, you know, adding that on as an  
3 adjuster for payment in a pilot sort of way. That  
4 would do two things. One is it begins to  
5 incentivize collection and use of these codes now,  
6 and the second is you could look at its potential  
7 feasibility. And, ultimately, it's outcomes using  
8 currently available measures. And if you drill  
9 down, some of these are actually pretty detailed.

10 The second idea is, and this is really  
11 for the ONC, is that one could begin to use  
12 internal data within the electronic health record  
13 to create perhaps, there would probably be  
14 indexes. One would have to see if they really  
15 coalesce together in terms of measures. But every  
16 time, for example, somebody changed their address,  
17 you had a count variable with the date, so you  
18 could look at frequency of change and address,  
19 frequency of change in a home and phone, frequency  
20 where there was no phone available, insurance  
21 change or period where there was no insurance  
22 listed. One could even look at missed



1 appointments and begin again to evaluate these as  
2 to what their impact was on other aspects of care,  
3 for example ED visits, re-admissions to hospitals,  
4 and other sort of relevant outcome measures.

5 CO-CHAIR PONCE: Great. Thank you.

6 I'm going to go to Bob, but we also have some  
7 committee members on the phone, and so I'm queuing  
8 you up after Bob's comment.

9 MEMBER RAUNER: I wanted to add a  
10 comment on Christie's comment about why the EHR  
11 data is so bad. Essentially, it's because what  
12 happened with meaningful use, especially stage two  
13 and three, there's an exhaustive laundry list of  
14 stuff that providers saw as not valuable to them.  
15 So, essentially, they're doing the minimum amount  
16 to pass that meaningful use audit. And the way to  
17 move forward is to get past the laundry list of  
18 meaningful use and things like reporting, for  
19 example, because the projects we're working on  
20 with clinics is, once they start using the data,  
21 they clean it up really quickly. And so the  
22 problem is if you can report on it, pull it, use

1 it, they'll clean it up really fast, and then it  
2 will become useful data for Christie and other  
3 researchers to get into it. It's the fact that  
4 meaningful use became the laundry list of  
5 bureaucratic requirements and there were no  
6 advanced clinical processes, which was the  
7 original intent of meaningful use originally. And  
8 so that's why our EHR data is so bad, but it could  
9 be great if we could fix these issues.

10 The other thing I want to add is about  
11 the immigration status issue is that in our  
12 community right now what's happening is our  
13 Hispanics community is really hunkering down and  
14 they're not wanting to share any information  
15 whatsoever because they're afraid IMS could be  
16 using that data to find them essentially. And so  
17 a lot of our community services, they're unwilling  
18 to, even things they might qualify, they don't  
19 want to give a name, they don't want to give an  
20 address, they don't give a phone number, and  
21 they're not spending money on anything because  
22 they're essentially saving for the storm. So it's

1 going to get really hard to do anything around  
2 immigration status, I think, until politics  
3 changes in the next year or two.

4 CO-CHAIR PONCE: Thanks, Bob. On the  
5 phone, Dave Nerenz.

6 MEMBER NERENZ: Nothing yet. It's  
7 okay.

8 CO-CHAIR PONCE: Great. Thank you.  
9 What about Yolanda, Yolanda Ogbolu?

10 MEMBER OGBOLU: Sorry. No comment.

11 CO-CHAIR PONCE: Great. Thank you.  
12 Any other comments from the group here? Susannah,  
13 Susannah Bernheim.

14 MEMBER BERNHEIM: Hi, it's Susannah.  
15 Just a request that sort of echoes what some other  
16 folks have said. I think it will be really  
17 valuable if this report not only talks about the  
18 potential data sources but weighs in on two  
19 particular issues that have come up. One is this  
20 sort of interagency collaboration, as I think  
21 Nancy pointed out. There are lots of places where  
22 data is available, but there's often a lot of

1 trouble. I mean, Social Security I think isn't  
2 even sharing basic death data with Medicare  
3 anymore. So if you guys can weigh in on where  
4 those opportunities are between agencies to make  
5 data that exists available, that would be one  
6 thing that would be really helpful.

7 And the other is, to your point, Karen,  
8 this question that we struggle with all the time  
9 of sort of what do we do with really rich data  
10 that's only available on a sample of patients. If  
11 you guys want to give some thoughts to sort of  
12 how, in the interim until the data is collected  
13 more consistently, it can or shouldn't be used  
14 within these measures, we would welcome more  
15 thoughts on that.

16 So those are things I'd love to see  
17 come out of your work. Thank you.

18 CO-CHAIR PONCE: Thanks, Susannah.  
19 Romana?

20 MEMBER HASNAIN-WYNIA: Hi. This is  
21 Romana Hasnain-Wynia, and I was just looking at  
22 the red box under or the boxes under gender for

1 gender identity and sexual orientation, and I just  
2 wanted to call out research that is currently  
3 taking place, particularly around the collection  
4 of both categories of gender identity and sexual  
5 orientation. So there is a study that is based at  
6 Brigham and Women's Hospital in Boston, the  
7 principal investigator is Adil Haider, H-A-I-D-E-  
8 R. And he is leading a study looking at patient-  
9 centered approaches to collect sexual orientation,  
10 gender identity information in the emergency  
11 department. Part of the reason for selecting the  
12 emergency department was because that was  
13 perceived as probably one of the most difficult  
14 places, given the intensity to collect this  
15 information.

16 The study is due to end in May of this  
17 year, so I think they're pretty far along. And I  
18 know that there's just not a lot of work in this  
19 area, so I wanted to highlight this as a potential  
20 source of evidence that might help guide data  
21 collection.

22 And I know that Ignatius Bau, who's

1 here, I think sits on the advisory, research  
2 advisory committee for this group, so I don't know  
3 if you want to add anything to that, Ignatius.

4 MR. BAU: The only thing is that the  
5 data is going to be really interesting because  
6 they not only tested ways to ask the question but  
7 also the formats, whether it's electronic, whether  
8 it's on paper, as well as who asked the question,  
9 whether it's the receptionist, whether it's the  
10 nurse, or whether it's the clinician, other  
11 clinician. So it's going to be a lot of really  
12 interesting data.

13 CO-CHAIR PONCE: We also did -- this is  
14 Ninez -- we tested gender expression among teens  
15 and gender identity among adults last year in a  
16 California Health Interview survey testing  
17 different ways of asking the question, and our  
18 response rate is pretty good. I can't really say  
19 exactly what it is, but I think it's under five-  
20 percent non-response. So we're moving forward.  
21 It is now asked at a population-based level.  
22 We're also thinking of asking both -- gender

1 identity and gender expressions are two different  
2 constructs among teens and adults.

3 But I see some more cards up, but I  
4 also wanted to ask, another data source would be  
5 looking at outside the health system, so looking  
6 at redlining types of data, you know, kind of  
7 looking at school data, expulsions. I think that  
8 that would be important. And I know that the data  
9 that HUD uses, I haven't kept track with the  
10 Senate bill and the congressional bill or the  
11 House bill, but I think there's some language now  
12 that they were going to get rid of some of this  
13 data if it were to show, if residential  
14 segregation were to show disparities. So it's  
15 very concerning, but that's the kind of data that  
16 if we show we're using it meaningfully that it's  
17 important to retain.

18 Philip and Susannah and then Ignatius.  
19 I'm sorry.

20 MEMBER ALBERTI: Just a quick addition  
21 to that conversation about the collection of  
22 sexual orientation and gender identity. I believe

1 it's UCSF that has actually changed their EHR a  
2 few years back and published how they did it, why  
3 they did it, what the question set is. So there's  
4 some evidence from that system that might be  
5 useful in this conversation, as well.

6 CO-CHAIR PONCE: It looks like we have  
7 a lot of expertise on gender identity and gender  
8 expression questions. Ignatius?

9 MR. BAU: And two last notes on that,  
10 as well. So another data source is the Federally-  
11 Qualified Health Centers in the UDS system, the  
12 uniform data collection system. Starting this  
13 year, every FQHC is going to be beginning to  
14 collect sexual orientation and gender identity.  
15 And so, again, more than EHRs, I think the FQHCs  
16 are going to do this sooner and we'll have that  
17 data more available.

18 I did want to make a note on this issue  
19 that, just as we had the discussion about gender  
20 versus sex, my comment on the NAM framework would  
21 actually move biological sex into the gender  
22 category and move sexual orientation into social



1 relationships because I think it's not a gender  
2 issue the way that this is framed, but that sexual  
3 orientation is more about who you're connected to,  
4 as opposed to who you're attracted to in terms of  
5 how it plays out in terms of the risk.

6 CO-CHAIR PONCE: I just had a quick  
7 question about acculturation. What went into that  
8 construct? I guess this is the slide that's up  
9 right now, so it's for the ASPE folks.

10 DR. JOYNT: That's a terrific question  
11 actually. I would have to flip back to read the  
12 report to actually see where they, how they define  
13 that. Yes, from the NAM report. Certainly, each  
14 one was an attempt to give sort of a title to  
15 themes that emerge from the literature, but I'll  
16 have to go back to the actual report to give you  
17 details on what that looks like.

18 CO-CHAIR PONCE: Great. Thank you.  
19 Okay. We're going to be open now for public  
20 comments on the phone.

21 OPERATOR: At this time, if you would  
22 like to make a comment, please press \* then the

1       number 1. There are no public comments at this  
2       time.

3                   CO-CHAIR PONCE: Thank you. And now  
4       we're opening up comments for those in the room.

5                   MS. ARGABRITE: Hi. Thank you all for  
6       this time. I want to just briefly say I'm honored  
7       to be with all of you, and I've learned quite a  
8       bit sitting in the back of the room. So thank  
9       you.

10                   My name is Shelley Argabrite. I'm from  
11       the Western Maryland region of Maryland. It's a  
12       small rural county of about 29,000 people, and I'm  
13       here to let you know that in the field we are  
14       engaging our community, and my role is a health  
15       planner and I'm in charge of two community  
16       processes. One is the Community Needs Assessment,  
17       and the second is the Community Health Improvement  
18       Plan.

19                   And we've instituted a digital platform  
20       for our community health improvement plan and have  
21       engaged over 7,000 people and increased  
22       representation by 1000 percent. It's about five

1 months old. And I just want to say that working  
2 together is the only way that we're going to be  
3 able to move anything at all, in our rural  
4 community especially.

5 And I heard a lot of discussion about  
6 multi-sectorial partnerships and accountability on  
7 the local levels and incentivization, and I just  
8 would implore you that, if there's a way to  
9 incentivize partners to work together, that would  
10 be, from my perspective, a really important piece  
11 because in the climate that we are operating in,  
12 it's all about funding. So if one organization  
13 has all the funding, they're less likely to work  
14 with other organizations. But the people that  
15 we're trying to serve are the same people. And so  
16 it kind of creates this competitiveness amongst  
17 organizations.

18 But something that has helped our  
19 community is accreditation. So we're recently  
20 accredited through PHAB, and the second is the  
21 Robert Wood Johnson Foundation. We're a finalist  
22 for the Culture of Health Prize this round.

1                   So that, in and of itself, has sort of  
2 woken up different agencies in our small town to  
3 say, oh, maybe we should be working closely  
4 together, and this is why.

5                   And then the final thing is that I'm  
6 here desperately seeking evidence-based measures  
7 on how I can prove that our communities, our  
8 agencies specifically, are working together and  
9 what impact that has. So I keep shaking my head  
10 when Eduardo says anything back there because I'm  
11 like, yes, we're doing that. But I'm just not  
12 quite sure how to take it to the next level.

13                  And so we have something pretty cool in  
14 this area. So I'm waiting because I can't find  
15 any measures. And so, for instance, when we were  
16 talking about an issue in our improvement plan,  
17 like tobacco, let's say. We are the worst in the  
18 state for tobacco use, so what role does the  
19 health planner does? What role does the hospital  
20 have? What role does the school system have? And  
21 we have on this digital open forum these strategy  
22 cards, and so every organization is inputting

1 their measures on how they're working on these  
2 certain issues. But it's all local level, and so  
3 I'm trying to find information on how to make that  
4 more evidence based.

5 But I would just say thank you for the  
6 work that you're doing, and I'm also seeking  
7 advice and help on how to publish something that  
8 we're doing. So I would offer that, as well.  
9 I'll be in the back.

10 CO-CHAIR PONCE: Thanks so much.  
11 Thanks so much for this really important voice  
12 from the field, and I know you also joined us  
13 yesterday.

14 DR. BURSTIN: Yes. And we'd be happy  
15 to send a link to what she's been doing with this  
16 incredible, I think Garrett County as an example  
17 maybe to start thinking about, if you think about  
18 what her needs are, how would that be useful?  
19 It's really extraordinary. So thank you for  
20 joining us.

21 MS. O'ROURKE: I think we are -- is  
22 lunch set up? I don't have a good visual.

1 DR. BURSTIN: I think it's almost  
2 ready. I have one sort of final question maybe.  
3 As we sort of think about the next discussion  
4 we'll have, once we feed you and give you a break  
5 because we realize we haven't given you a break in  
6 a very long time -- nobody has left, which is  
7 really compelling. Obviously this has been a good  
8 discussion.

9 You know, as you think about this  
10 discussion, I want to say a special thank you,  
11 obviously, to Karen and her ASPE colleagues and  
12 Sarah for giving us so much food for thought. As  
13 we think about this next discussion, and one of  
14 the next discussion issues is around these  
15 unresolved issues, one of which is around these  
16 hospital factors, community factors. As you  
17 listen to this conversation, what might rise to  
18 sort of the next tier of things for us to push on  
19 in terms of what might be doable? Some of these  
20 seem very long term, getting data collected on  
21 site, a fabulous, best source of data, but  
22 probably a longer trajectory to getting to them.

1                   So I love your good thoughts, even if  
2                   you did it while you were eating, about what might  
3                   logically rise to something more usable in the  
4                   shorter term.

5                   MS. O'ROURKE: So I'd just echo Helen's  
6                   thanks to Karen and her team and Sarah for sharing  
7                   your work. Why don't we give you guys a break?  
8                   Lunch should be up momentarily, and then maybe we  
9                   could come back around 12:15 to perhaps answer the  
10                  question Helen just put to the group and start to  
11                  think about some of the challenges that have come  
12                  up through the trial period and next steps there,  
13                  but I think everyone looks like they could use a  
14                  few minutes away from the table. So why don't we  
15                  come back around 12:15?

16                  (Whereupon, the above-entitled matter  
17                  went off the record at 11:45 a.m. and resumed at  
18                  12:27 p.m.)

19                  MS. O'ROURKE: Okay, so why don't we go  
20                  ahead and get started.

21                  So, I think we're going to shift gears  
22                  a little bit here. And we have some questions for

1       you about some of the issues that have come up  
2       from NQF's trial period where we allow our  
3       measures to consider social risk factors in their  
4       risk adjustment models.

5               I think with that I am going to  
6       introduce Helen to go through a few quick slides  
7       with you, and then some conversation.

8               DR. BURSTIN: Great. Thanks,  
9       everybody.

10              So there are a series of these  
11       unresolved issues that we have been encountering  
12       in the two years -- almost two years since we  
13       started the trial period. And I wanted to queue  
14       up this particular issue for you but give you the  
15       overall context first.

16              So, as an example, when the NQF board  
17       recently endorsed a set of readmission measures  
18       without adjustment -- because again the data  
19       available and the analyses, as done, did not show  
20       a significant difference -- the -- initially the  
21       Consensus Standards Approval Committee as well as  
22       the board came out with these four recommendations



1 to attach to the endorsement decision. I just  
2 wanted to put these up there.

3 So, the first was, again, around  
4 readmissions, important to consider other  
5 approaches beyond measurement adjustment as the  
6 only potential approach here.

7 A broader issue that I very much would  
8 like us to spend some time working on as an  
9 organization, which is really focusing not just on  
10 social risk versus medical risk but thinking about  
11 what's the next generation of risk adjustment,  
12 including social risk, but also, a really  
13 important piece in the ASPE report was this  
14 concept of unmeasured clinical complexity.

15 So, for example, if we began to put  
16 frailty or functional status into risk models, how  
17 much would we begin to see perhaps some of what we  
18 think we attached to social risk may really be  
19 about this unmeasured clinical complexity. And  
20 even just -- even on the clinical side, the idea  
21 that we're still using, largely, claims data to do  
22 risk adjustment without the level of precision you

1 may need about, you know, levels of congestive  
2 heart failure, et cetera. It's pretty difficult  
3 to do.

4 The next one was directed specifically at  
5 you, which is the Disparities Committee will help  
6 address unresolved issues and concerns regarding  
7 risk adjustment approaches, including the  
8 potential for adjustment at the hospital and  
9 community level. And when these readmission  
10 measures, for example, came up for discussion at  
11 both the Readmission Committee as well as the  
12 CSAC, a lot of discussion was on, well, why can't  
13 we get beyond these individual patient factors as  
14 being the only way to look at this issue?

15 So -- and then the last one is just for  
16 your sake as well. We are including as part of  
17 many of these measures that have been adjusted  
18 without -- that have been endorsed without  
19 adjustment, we have actually required that as part  
20 of the usual NQF annual update process they have  
21 to come back on an annual update and give us an  
22 update of whether additional SES adjusters are

1 available.

2 Next slide.

3 So, queued up some unresolved issues  
4 for you. Hospital and community factors we will  
5 come back to and do a little deeper dive on in a  
6 moment.

7 But there have been some interesting  
8 conversations about what the SES -- Kevin and  
9 others of you who are on it -- meant by a  
10 conceptual basis and how tight should that be. So  
11 we've seen lots of variations of that: conceptual  
12 basis for the literature, conceptual basis by  
13 literally drawing out a driver diagram and being  
14 very explicit about which factors could relate.  
15 Some of the driver diagrams have been very  
16 oriented to data available now, as opposed to what  
17 might actually be the drivers, but data not  
18 available.

19 So a second issue. For the sake of the  
20 trial period -- although the SES report said all  
21 kinds of measures were potentially acceptable for  
22 adjustment, including process measures, et cetera

1       -- we have mainly focused on outcome measures  
2       because for the sake of the trial period it's  
3       adding variables to a risk adjustment model. And  
4       so we couldn't really wrap our heads around how  
5       you would then move towards considering social  
6       risk adjustment for process measures that don't  
7       actually have one, with the possible exception of  
8       stratification.

9               So, raises another unresolved issue for  
10       us as we think about what we might do in the  
11       future. Is that something we would do? And if  
12       so, what guidance could you offer us?

13               This broader issue of stratification  
14       versus adjustment, how would adjustment be used?  
15       And I know, for example, Sarah and Mara just  
16       presented with me at the SNPA -- Special Needs  
17       Plan Alliance -- some of the research you've been  
18       doing around looking at potential ways of  
19       stratifying among the special needs plans to see  
20       if those institutionalized versus not as you look  
21       at the measures differently. But how that  
22       actually gets used in a payment approach I think

1 is still pretty open.

2 And then very much a question -- open  
3 question of we have heard a lot from the hospital  
4 community. We are happy to share a letter we just  
5 got from the collective hospital associations on  
6 this of whether we've been proscriptive enough --  
7 prescriptive, I don't know which word it is --  
8 about the empirical approach to risk adjustment.  
9 So we have seen some examples where, you know, the  
10 approach has been move all the clinical factors in  
11 and then consider the additive effect of social  
12 risk. The impact report I think didn't make that  
13 assessment, for example, and put all factors in as  
14 significant and whether you'd see different issues  
15 there.

16 So I think one unresolved issue broadly  
17 for all of you and us to think about is what  
18 additional guidance we would do, regardless of  
19 what we decide to do with the trial period going  
20 forward.

21 And I will just cue it up for you and  
22 we'll come back at the end. Are there other

1 unresolved issues as we sort of walk through this  
2 this afternoon that you think we should get some  
3 clarity on as we move forward?

4 Next slide.

5 So, the hospital and community factors  
6 in particular. Our measure submission form  
7 currently follows what's in the SES Risk  
8 Adjustment Report which specifically focuses on  
9 patient-level SDS factors. Asked whether they  
10 were analyzed -- available and analyzed. And some  
11 folks have raised concerns about hospital-level  
12 factors as well as community-level factors.

13 Hospital-level factors are really not  
14 discussed in the SES Expert Panel Report. But  
15 there was a small section on the use of community  
16 variables as a way to characterize the patient's  
17 living environment, potentially to be used as a  
18 proxy for patient-reported data. And then to  
19 understand how community factors affect the  
20 healthcare unit.

21 We have not seen variables come forward  
22 that use these, with the exception of some use of

1 some of the current population survey data in the  
2 AHRQ deprivation index. But even that is still  
3 fairly, you know, not necessarily just taking a  
4 community-level factor and thinking about how that  
5 weighs in.

6 For example, Dave Nerenz -- who is on  
7 the phone -- can certainly speak to some of the  
8 analyses that have been done elsewhere where  
9 you've looked at -- for example, a Health Affairs  
10 paper looked at percent vacancy in a community as  
11 a risk adjuster for readmission rates, finding  
12 that to be quite significant. So, a sense of  
13 community, I guess, level deprivation, or however  
14 you might want to frame that.

15 Hospital-level factors have been raised  
16 with a lot of concerns, frankly. Would you then  
17 be adjusting for what might be factors that may in  
18 fact be driving poor quality care or differential  
19 quality of care?

20 So, this is just an example of the  
21 kinds of issue. We would love to have you spend  
22 a little bit of time with us today.

1                   So, next slide, please.

2                   So first, do you have any guidance for  
3 us to offer to measure developers on how to  
4 consider hospital- and community-level factors.  
5 You can separate them. We can talk about them  
6 separately.

7                   And in particular, we want to then be  
8 able to also then provide guidance to our standing  
9 committees as they look at measures and they raise  
10 issues about, well, what if you looked at -- you  
11 know, what if you looked at percent dual-eligibles  
12 at a hospital? You know, what guidance do we then  
13 give back to the standing committees as they  
14 review those?

15                  And then as we think about this  
16 conversation this morning we had about data, what  
17 hospital- and community-level factors would you  
18 even consider or should be potentially explored?

19                  And then if you have a sense of how we  
20 should help with you over the next coming months,  
21 years, think about how to address the other  
22 unresolved issues. And I will cue up the question



1 from the earlier page which is, are there any  
2 other unresolved issues you feel like we haven't  
3 captured?

4 And just to keep you oriented, the next  
5 section we'll walk through the -- our at least  
6 approach for the evaluation plan for the trial  
7 period and get some early insights from you about  
8 the plan and the approach. But why don't we cue  
9 this up for discussion now.

10 CO-CHAIR PONCE: Thoughts from the  
11 committee?

12 CO-CHAIR CHIN: I guess while people  
13 are forming their questions, has there been a  
14 review of the literature regarding these issues,  
15 internally or otherwise?

16 DR. BURSTIN: I think we have looked as  
17 they have come up. But we have not found anything  
18 systematic. And I don't know if others around the  
19 table have.

20 CO-CHAIR PONCE: Bob?

21 MEMBER RAUNER: My question is, so a  
22 lot of this is based on hospital data because, you

1 know, readmission rates, for example, is such a  
2 big deal for CMS. But one of the problems is that  
3 all that data is all most often just Medicare-  
4 based claims data, for example. But the people  
5 working with the most disparate populations rarely  
6 have people at federally qualified health centers,  
7 for example. There is a lot of data within those  
8 FQHCs in our -- we have some Nebraska projects  
9 where you can look at screening rates by ethnicity  
10 and insurance status, and you're seeing huge  
11 changes. But I've never seen much published in  
12 that area.

13           So it's just that I think there's  
14 really just not a lot of stuff being published yet  
15 because nobody's operating as much in that sphere  
16 to publish that stuff. It's out, it's there, it  
17 can be pullable and you could look at those  
18 things. But I just don't know if it's out there  
19 in the published literature. So it's there, it's  
20 real, I think it needs to be done but we just  
21 don't have the studies in Health Affairs to go  
22 look at.

1                   MEMBER ALBERTI: A couple of thoughts  
2 here. So, in terms of the evidence base of, you  
3 know, neighborhood or contextual factors on  
4 health, that's a huge literature. So maybe it  
5 would be wise for us at some point to have people  
6 like Anna Diaz kind of come and talk about these  
7 multi-level models that really demonstrate both  
8 individual as well as aggregate and community  
9 level impacts on health and health outcomes.

10                   You know, I am intrigued by the light  
11 green box that we just saw for a neighborhood  
12 deprivation index. There are a lot of really  
13 interesting metrics that are kind of aggregate  
14 variables that pull together different aspects of  
15 a community. That's in NAM and ASPE's light green  
16 box. I think that's something for us to look at.

17                   We talked very briefly, you know,  
18 thinking about what it would mean to find  
19 jurisdictions or states or communities that  
20 actually have comprehensive community data  
21 available. So even if we can't conduct, you know,  
22 an empirical test based on nationally

1       representative data, I think certainly some of our  
2       empirical models could be assessed, you know,  
3       whether it's in New York City or in California, or  
4       places where we know they're spending the time and  
5       the money to do the kinds of over-samples of BRFSS  
6       data or YRBSS data that allow you to get -- to  
7       drill down more than a 5-digit ZIP Code or even  
8       more than a 9-digit ZIP Code just to see if some  
9       of these constructs that we -- I think we would  
10      all draw very similar conceptual models for  
11      readmissions on the kinds of variables upstream in  
12      communities that would lead patients to be more  
13      likely readmitted, whether it's social isolation,  
14      whether it's lack of heat and hot water, lack of  
15      food access, lack of transport. I mean, we know  
16      these things have impact.

17               So, if there are places where we  
18      actually have good data that could be matched to  
19      hospitals -- I think about is it possible to get  
20      a coalition of New York City hospitals together?  
21      Thinking of combine their data, look at  
22      neighborhood level data, and run some of these

1 tests that could at least inform the aspiration  
2 for an eventual kind of robust adjustment that  
3 includes both clinical risk factor, patient-level  
4 social risk factor, as well as neighborhood and  
5 community risk factor data.

6           You know, I think the tension is we  
7 have these beautiful, robust conceptual models and  
8 just a lack of ability to test them with the data  
9 that we have. I don't know if we have the teeth  
10 -- you know, who's going to come up with those  
11 data? Who's going to pay for the collection of  
12 those data? Those aren't easy answers. But if  
13 there are places that can help us now think  
14 through whether it's even worth making those  
15 suggestions, I think that's a good step forward.

16           CO-CHAIR PONCE: Thank you. Bob?

17           MEMBER RAUNER: A follow-up to that,  
18 has anybody reached out to HRSA? Because the UDS  
19 measures are all migrating toward NQF measures.  
20 And every FQHC in the nation submits all its UDS  
21 measures to HRSA, I think, quarterly. They've got  
22 demographics in all the FQHCs. You could probably

1 link them back to the local hospitals that work in  
2 their catchment areas. Maybe it's a silo problem  
3 where you've got, you know, NQF here, CMS over  
4 here, HRSA over here. If they got together they  
5 could -- they might be able to put some of this  
6 stuff together.

7 CO-CHAIR PONCE: There was a HRSA  
8 representative yesterday. And that data is  
9 available right from the UDS Mapper. So that's  
10 already available.

11 MEMBER RAUNER: Yeah, it's right on the  
12 website.

13 CO-CHAIR PONCE: Yeah.

14 MEMBER RAUNER: But it's all aggregate  
15 though, so.

16 CO-CHAIR PONCE: It is aggregate.

17 MEMBER RAUNER: But the source of that  
18 data in all of these --

19 CO-CHAIR PONCE: Yeah.

20 MEMBER RAUNER: -- FQHCs is patient  
21 level actually.

22 CO-CHAIR PONCE: And Kevin and I worked

1 on a project called CHARN. And it's -- there's  
2 individual level data for clinic networks --  
3 APCHO, OCHIN, Fenway, and the Alliance. It's not  
4 100 percent of -- you know, it's not all -- it's  
5 not all the clinics for each network and it's not  
6 all the networks in the U.S. But I think it's --  
7 it's a start.

8 So I think the question -- I'm not sure  
9 if it answers any of these questions -- but the  
10 questions on how to do the -- to add these  
11 measures. And, Helen, you said the way it's  
12 usually done is you put in the clinical factors.  
13 And then once you add even more clinical factors  
14 like functional status, and when you add the  
15 social factors then the social factors don't add  
16 very much.

17 And so you're already kind of into this  
18 pathway of defeating the argument that social  
19 factors matter. And I will need to read the ASPE  
20 report more carefully, but in the presentations  
21 that Karen has presented -- not just today but I  
22 think about a month or two ago -- it looked like

1 they looked at social factors first. So, they  
2 looked at the relationship with social factors put  
3 in first. And then they brought in the others.

4 So that's a different approach because  
5 you're already -- you know, you're already kind of  
6 saying that social factors matter, so let's look  
7 at it first, and then see how then it gets  
8 diminished with the others. So it's -- in a  
9 saturated model, it looks like you'll end up the  
10 same way. But somehow it puts forth the value  
11 statement that we think social factors matters  
12 first seem to be more apparent in the way that the  
13 ASPE model approached it.

14 So now I see Nancy and Lisa, and then  
15 Eduardo.

16 MEMBER GARRETT: So, you know, in terms  
17 of the question about hospital- and community-  
18 level factors, I guess my opinion is absolutely  
19 they should be explored. I mean, as a member of  
20 the SES Panel, I don't think we intended to  
21 exclude those from the report. I think it was  
22 just that we ended up focusing a lot on individual



1 factors because we were looking for the  
2 characteristics of the population that would be  
3 not actually measuring quality of providers but  
4 measuring something else.

5 But we just didn't really get to it.  
6 We didn't have enough time. So I don't think it  
7 was purposeful that we said those are not  
8 important. And I think it's really about the  
9 conceptual model for what factors might affect  
10 whatever variable it is that's being measured.  
11 And there are criteria in the report to consider  
12 whether or not something would be something that  
13 we'd want to risk adjust for. And one of them is  
14 whether that variable might be confounded with  
15 quality of care.

16 And so if a hospital-level variable  
17 would meet that -- for example, if you were  
18 looking at payer mix as a possible adjuster --  
19 maybe that would be confounded with quality of  
20 care in the sense that hospitals with more  
21 Medicaid patients are going to have fewer  
22 resources to address the variable and, therefore,

1 have lower quality. So, in that case you might  
2 decide not to use it as a risk adjuster but it  
3 might be a really important variable from a health  
4 equity standpoint of are we getting the resources  
5 to the right place, right.

6 So, it kind of moves us beyond risk  
7 adjustment into what other mechanisms do we have  
8 to address health equity. And so there's -- you  
9 know, I think there's limited utility for what  
10 risk adjustment itself can really do.

11 So those are a couple of thoughts about  
12 that.

13 And in terms of the question about  
14 whether it should just be outcomes of variables,  
15 I really like the construct in one of the National  
16 Academy of Medicine reports of the idea of  
17 categorizing measures for whether they are social  
18 risk factor sensitive or not. And I think that  
19 might be a more useful frame so that you might  
20 say, okay, if measures based on conceptual -- kind  
21 of the model that we have, not necessarily based  
22 off the literature just because we don't have good

1 research on all of this -- but if conceptually  
2 there's a strong relationship to social risk  
3 factors like a diabetes outcome measure, then we  
4 might say, okay, that measure we really do need to  
5 look at risk adjustment.

6 But if it's one where it's really some  
7 processes that are really very much in the control  
8 of a care system, maybe that is not something that  
9 we would look at this.

10 And so I think that's more useful to me  
11 than outcomes versus process measure because we  
12 might imagine things in both of those categories  
13 that could still have social risk factor  
14 adjustment needed.

15 CO-CHAIR PONCE: Thank you. Lisa.

16 MEMBER IEZZONI: Thank you.

17 Adjusting for hospital factors does  
18 make me a little bit nervous about masking, you  
19 know, potential outcomes that really are  
20 associated with certain hospital variables. And  
21 so I'd really need to talk it through with better  
22 statistical minds than mine to feel really

1 comfortable about adjusting for hospital factors.

2 Community factors I feel quite  
3 differently about. But the hospital factors I  
4 think they are two different things. And having  
5 them in the same question I think really fails to  
6 kind of recognize that those are very two distinct  
7 things.

8 I would suggest that you maybe look  
9 around the country and see whether there are any  
10 interesting risk adjustment models happening in  
11 any of the states that are implementing some of  
12 the new demonstration programs for the duals. In  
13 Massachusetts, the One Care program, we have had  
14 some challenges with our risk adjustment because  
15 the -- and this is admittedly for payment, not for  
16 quality measurement, but they are kind of flip  
17 sides of a similar coin -- we have had to kind of  
18 revise the way that it was approached because the  
19 payment was systematically under what it needed to  
20 be.

21 And, Helen, remember the days 20 years  
22 ago plus when Arlene Ash and John Ayanian and you

1 and I and David Bates worked together on the PIP-  
2 DCGs? Remember those? Well, Arlene is still  
3 working in this area. And she actually had a  
4 contract with the state of Massachusetts to use  
5 information about a person's eligibility for some  
6 of the state support programs -- for example for  
7 mental health, and so on -- and using that in risk  
8 adjustment models.

9 And from what I understand, it has  
10 produced some very, very powerful results. And so  
11 you might want to check with her and see whether  
12 there are some other people who are really on the  
13 cutting edge of this who could bring in some kind  
14 of really like right out there on the kind of  
15 forefront of where things are right there out in  
16 the different states that are kind of doing these  
17 payment experiments.

18 DR. BURSTIN: One quick thought.  
19 That's great, Lisa. Very helpful.

20 I just want to point out, it wasn't  
21 intended that those were the same questions. It's  
22 just the question for you is consider hospital,

1 consider community, not together. And I fully  
2 recognize you may walk out of this room with very  
3 different answers to both of those. So just  
4 wanted to tee up both of them as being unanswered.

5 CO-CHAIR CHIN: And just to say that  
6 those days 20 years ago when Helen was a faculty  
7 member at Harvard, her office was literally a  
8 closet.

9 DR. BURSTIN: It was a closet. It was  
10 so small, actually -- if you really want to get  
11 crazy, so this was David Bates' office the year  
12 before. And he got to move to the closet next  
13 door that had a window. And I moved into the  
14 closet without a window. And I had a Tiffany  
15 print on the wall to make me feel like it was not  
16 in a closet.

17 CO-CHAIR PONCE: Sarah.

18 MEMBER SCHOLLE: So a couple of  
19 thoughts from my team back at the ranch who are  
20 very quick on responding to questions I send to  
21 them.

22 So on the hospital, I think there is

1 some concern also about the hospital. It might be  
2 helpful to think -- and the question they are  
3 asking is what measures and what's the accountable  
4 entity? Because if we think about health plans,  
5 they have some way of selecting -- often, maybe  
6 not always, they have some way of selecting  
7 hospitals. And we're incentivizing hospitals. So  
8 maybe that's an approach. And for readmissions  
9 you wouldn't want to -- it feels less comfortable.  
10 It seems like there are other ways to address the  
11 hospital issues there.

12 But community factors, yeah, that makes  
13 -- that makes sense there.

14 The other issue that they brought up,  
15 which is in the nitty-gritty of who is going to do  
16 this risk adjustment and how? And so the  
17 reporting approach is important.

18 Where for some of the measures that CMS  
19 looks at there's a contractor that does the  
20 reporting, the calculation for everybody.

21 And then for NCQA measures we tend to  
22 push as much of the data to the health plans to do

1 the calculation. And so it really depends on how  
2 that reporting is happening. There's a lot of  
3 room for error. And the more complex the measure,  
4 the more challenging it is to get apples to apples  
5 comparisons. So that's another issue to consider  
6 in how we take into account these factors.

7 CO-CHAIR PONCE: Christie. Oh, I'm  
8 sorry, I keep forgetting Eduardo. Eduardo and  
9 then Christie.

10 MEMBER SANCHEZ: I will speak at the  
11 likelihood that I'm going to look quite ignorant  
12 in my question and comment. But it seems to me  
13 that one of the questions to ask ourselves is risk  
14 adjustment for what -- for what purpose? And then  
15 think about the unintended consequence of risk  
16 adjustment. And understand that sometimes  
17 pointing out differences rather than risk  
18 adjusting for them then allow us to address the  
19 difference, not try to erase the difference. If  
20 that's making any sense.

21 So as I think about hospital factors,  
22 it may -- it may suggest approaches to fixing the



1       disparity as opposed to adjusting for the  
2       disparity. And the same goes for the community.

3               And as I thought about particularly the  
4       issue that you raised, Ninez, about clinical  
5       factors, functional factors, then erasing social  
6       factors, you still need to look at the social  
7       factors because the strategies to address what  
8       might appear to be clinical and functional issues  
9       might be best addressed with a social level  
10      intervention as opposed to a clinical or  
11      functional intervention.

12             CO-CHAIR PONCE: Right. I'm just going  
13      to comment on that.

14             And I think Philip mentioned multi-  
15      level models and Anna Diaz sort of possibly coming  
16      here. But if it's modeled also -- if the  
17      community levels are modeled as, you know, a  
18      separate model, and then there's cross-level  
19      interactions, then you actually can get some  
20      insight. So it's not just washed out.

21             CO-CHAIR CHIN: Let me jump in for a  
22      sec. So, Eduardo, my dad taught me that when

1 someone starts a question by saying this may be a  
2 naive question or a stupid question, these are the  
3 guys that have the really smart questions.

4 MEMBER SANCHEZ: Able to fool you on  
5 all fronts.

6 CO-CHAIR PONCE: Everybody's going to  
7 follow you home.

8 CO-CHAIR CHIN: And I think like your  
9 point about, like, the purpose of risk adjustment  
10 went to a fundamental issue that we struggle with,  
11 with the committee that Kevin and David and Nancy  
12 and others and I were on, is you don't want to  
13 sort of whitewash away disparities, but you don't  
14 want to punish the safety net providers that --

15 MEMBER SANCHEZ: Totally agree.

16 CO-CHAIR CHIN: So some of us have a  
17 question that the issue you bring up and Nancy  
18 brings up, in some ways starts tying into the next  
19 charge we have of, like, the policy part of this.  
20 And one of the things that made the committee --  
21 the last committee hard was that there was that  
22 firewall and that we just couldn't think about

1 then the full panoply of tools of recommendations,  
2 which now we do.

3 And so, the question for you, Helen, is  
4 that you -- partly you frame this as, well, for  
5 risk adjustment, that is regarding this. You do  
6 leave this sort of last bullet about other issues.  
7 And that becomes this interesting thing where it  
8 gives it a little more flexibility. And so have  
9 you thought to us -- like what advice you might  
10 have to us as a committee in terms of the then --  
11 how we might simultaneously look at this.

12 Because, again, like if you're just  
13 locked into looking at risk adjustment, you're  
14 limited. Whereas, looking at the full panoply,  
15 then you're just going to say what Nancy used to  
16 talk about, like the stratification, for example,  
17 and ways of looking at quality that go beyond  
18 again, like, sure, risk adjustment. So have you  
19 thought about, like, how we might start thinking  
20 about this?

21 DR. BURSTIN: Absolutely. So this is  
22 very much -- teed this up around the concept of

1 our trial period. And, again, depending on what  
2 we wind up doing with it moving forward. But  
3 these are issues we have encountered, as the  
4 measures have been submitted as part of the trial  
5 period, to consider for adjustment. So that's why  
6 this is adjustment framing. But this committee is  
7 free to think about it, and I think one of the key  
8 open issues is going to be, you know, do we move  
9 forward with recommendations that move beyond, you  
10 know, adjustment as the only approach?

11 And, in fact, if you look at the  
12 beautiful SES report that many of you on this  
13 committee wrote, it does lay out that adjustment  
14 is a potential strategy, stratification is another  
15 strategy, payment is a third strategy. But I  
16 think we got so focused in on the risk adjustment  
17 because it was the issue at hand, and it continues  
18 to be in many ways the issue at hand.

19 And just to remind us, with your  
20 guidance what we actually wound up doing is that  
21 as measures are submitted for the trial period, if  
22 they are adjusted, we require that the

1 specifications include both the adjusted measure  
2 plus the stratified specifications because we do  
3 not want to get into this issue of masking.

4 And so that has been there from the  
5 start. And, again, as you'll hear as we go  
6 through, you know, when we start bringing you the  
7 information back, not surprisingly back to the  
8 prior discussion, a lot of this comes back to do  
9 we have the right data at hand? And I would argue  
10 do we have the right data in hand for adjustment,  
11 stratification, targeting, improvement. And I  
12 think it's the same data. It's a question of the  
13 various ways you could use it. And you should  
14 feel very open to thinking about all those  
15 different levers.

16 In this context, though, we are trying  
17 to think about as measures come forward, often for  
18 public reporting and payment. So not thinking  
19 about how you would use them for targeted  
20 improvement. And adjustment, certainly one of the  
21 strategies listed in the ASPE report, how do we  
22 handle, even within that context of adjustment,

1 some of these unanswered questions?

2 But feel free to think broadly.

3 CO-CHAIR PONCE: Christie.

4 MEMBER TEIGLAND: So I want to go back  
5 to something we talked about a couple of times  
6 yesterday, which is the only within-plan  
7 disparities are true disparities, and differences  
8 between plans are not. And how I really don't buy  
9 that for the Medicare Advantage population.

10 And I will just throw some data out at  
11 you as to why I don't believe that.

12 So, 85 percent of the plans are either  
13 in -- have 20 percent or fewer duals. So they are  
14 largely non-dual plans. And then -- or they have  
15 80 percent or more duals. So they are largely  
16 dual plans.

17 Only 15 percent of the plans in the  
18 middle have more than 20 percent of either duals  
19 or non-duals. There's a very small -- so there's  
20 a very small subset of plans, only 15 percent,  
21 that really produce some pretty, you know, decent  
22 within-plan differences.

1                   You know, and the plans are very  
2                   different in size. So the non-dual plans are --  
3                   their average size is about 37,000 members for  
4                   those plans that have 20 percent or fewer duals.

5                   The plans that have 80 percent or more  
6                   duals, their average size is only about 3,500  
7                   members. And they're 80 percent dual.

8                   The other 20 percent that are non-dual  
9                   my belief is -- and I want to test this -- is that  
10                  they look more like the duals, right, in those  
11                  plans. There's not -- you're not going to see a  
12                  lot of within-plan disparity there. You are also  
13                  probably not going to see a lot of within-plan  
14                  disparity in these very large plans that have only  
15                  a small portion of dual eligibles in them. Sort  
16                  of really see those disparities.

17                  And I think that was proven out by the  
18                  CAI adjustment -- the categorical index adjustment  
19                  that CMS did -- which changed the Star Rating of,  
20                  like, two plans, right, overall. Because those  
21                  differences that they found were so small.

22                  Now, when you look at the risk scores

1 of those 20 percent or fewer dual plans, their  
2 average risk score is only about 0.8. And the  
3 average risk score of the plans that are 80  
4 percent or more dual is about 1.47. More than  
5 double. They are very sicker, very much more  
6 complicated.

7 So is it really -- do we really believe  
8 that the differences in Star Ratings between those  
9 low risk score, non-dual plans are providing a lot  
10 better quality than those, right, plans? And  
11 we've done some testing of that. And I'm not  
12 convinced that that's true.

13 So, you know, most of them measure only  
14 one of the real outcome measures in this, in the  
15 Medicare Advantage Star Ratings plan -- and I'm  
16 talking about the outcome measures. Some of the  
17 CAHPS measures were obviously risk adjusted for  
18 some of these other factors -- aren't even  
19 adjusted for clinical risk factors. And we've  
20 talked about that, Helen.

21 So, you know, adjusting for clinical  
22 risk factors would take -- it would get some of



1 that, you know, risk score -- higher risk score,  
2 higher complexity, higher burden of illness. But  
3 even when we do that, we still do find that  
4 poverty has an effect, dual status has an effect.

5 And so, you know, then we talk about,  
6 well, what does it do to the distribution of plans  
7 and how they rank? And what I'm concerned about  
8 with the stratification is that you're letting  
9 plans who don't have a lot of duals, and have a  
10 pretty easy, wealthy, healthy population, sort of  
11 off the hook.

12 Because when we risk adjusted and  
13 looked at how the ranks changed of plans, the best  
14 plans stayed the best regardless of where they  
15 were. Right? The worst plans stayed the worst.  
16 But there was a lot of movement in the middle.  
17 But both getting some plans ranking far worse than  
18 they did. Because guess what, they're doing a  
19 worse job than you would expect given the  
20 population they have.

21 You are not going to see that in  
22 stratification. So I would argue, Helen, that

1       that's not going to not mask disparity. I think  
2       it is still masking disparities. And, you know,  
3       when you risk adjust for these -- all of these  
4       characteristics, you're saying for these plans  
5       that serve these very disadvantaged populations,  
6       who's doing a good job and who's doing -- who's  
7       not? Who's doing the worst job? You're still  
8       getting at those bad actors type thing.

9               So, I would argue against, you know,  
10       against a lot of -- I think, you know, the opinion  
11       about masking disparities, I think you're doing it  
12       with stratification as well.

13              And I disagree with only adjusting for  
14       within plan differences. You're not going to find  
15       very many, at least in the Medicare Advantage  
16       population, the way the plans are distributed.

17              CO-CHAIR PONCE: Thank you. Point well  
18       made.

19              And you've presented some of this data  
20       to this committee.

21              Nancy.

22              MEMBER GARRETT: Just to follow on your

1 comment, Christie, about stratification. I also  
2 have concerns about stratification as an answer to  
3 this problem we're facing. And one of the reasons  
4 is, is because no matter how you define the groups  
5 you're still going to have variation within that  
6 group. And so you can't -- it doesn't do away  
7 with the problem we're trying to solve.

8 And, I mean, just as one example that  
9 we experienced, our state was trying to look at  
10 ways to stratify hospitals. And so they said,  
11 well, we'll have a safety net category. And so  
12 they put HCMC into a category with another  
13 hospital in Minnesota. And the populations are  
14 very different and, to me, not comparable. But  
15 now we have a group of two, and we've fixed the  
16 issue.

17 And so it's just an example of how it's  
18 limited in what you can really do with  
19 stratification.

20 CO-CHAIR PONCE: Dave.

21 Oh, Susannah joining then? Oh, she's  
22 on the -- oh, Dave or Susannah or Yolanda. Let's

1 go with Dave first. Let's go with Dave first,  
2 then Susannah, then Yolanda.

3 MEMBER NERENZ: Okay, thanks. So this  
4 is a really important discussion. The only thing  
5 I wanted to address -- and this actually probably  
6 applies back to several comments ago about, you  
7 know, what's the purpose of adjustment, and  
8 essentially why we're having this discussion.

9 I think there is a practical answer.  
10 And then I can also speak a little bit to this  
11 conceptual model that Helen raised. And a lot of  
12 the CMS programs particularly you have payment  
13 incentives but also you have public reporting.  
14 And readmission is a prime example. But we have  
15 other ones. We have the health plan Star Ratings,  
16 we have other things.

17 And in all of those programs when the  
18 underlying concept is being described, the word  
19 quality is used. That these are quality measures.  
20 And we're talking about high quality hospitals or  
21 high quality health plans, or low quality  
22 hospitals.

1                   And I think the fundamental question is  
2                   when that's done in the instance of adjustment, on  
3                   the payment side then are the actual payment  
4                   incentives applied fair, meaning are the hospital  
5                   quality measures really truly reflecting  
6                   underlying quality?

7                   And on the public reporting side the  
8                   question is are these public measures to be used  
9                   for consumer choice accurate? Are they fair? Are  
10                  they right? If a number indicates that a hospital  
11                  is high quality, is that true? Is that really  
12                  true?

13                  The reason I think our group a couple  
14                  years ago now got to the point we got to is that  
15                  when you think about, particularly outcome  
16                  measures -- this is not so much directly relevant  
17                  to process measures, but certainly outcomes -- if  
18                  you just draw it out -- and I have to kind of do  
19                  it in the air here, but maybe somebody in the room  
20                  could do it more concretely -- you know, draw a  
21                  classic boxes and arrows diagram where you've got  
22                  the outcome on the right-hand side, and then

1       you've got a bunch of arrows feeding it. I think  
2       what our group -- and we had this in front of us  
3       a couple times -- that quality is one -- and I  
4       emphasize one -- of several boxes that then feed  
5       the outcome. It's not the only thing.

6               And if those other things are moving  
7       the outcome measure around through causal pathways  
8       that do not involve quality, then there's a strong  
9       case for adjustment because the resulting number  
10      does not accurately and truly reflect quality.

11              I think that's kind of the heart of  
12      what we were talking about. And then, obviously,  
13      in any case you have to decide, you know, is there  
14      a model like that? Are there pathways like that  
15      that do not involve quality? And if so, then at  
16      least there's the conceptual model of a case for  
17      adjustment.

18              Now then, you know, you have to get  
19      into the weeds then, whether we're talking about  
20      this measure or that measure, this organization,  
21      that organization, you know, does that situation  
22      exist?

1                   And then do you have same thing you  
2                   switch over to the empirical side. If you have  
3                   with the variables you have available, can you  
4                   actually develop a model that seems to  
5                   appropriately adjust? And that's kind of the --  
6                   that's what we're into right now.

7                   CO-CHAIR PONCE: Thanks, Dave.

8                   Susannah.

9                   MEMBER BERNHEIM: Yes, I'm on the  
10                  train, so if it's unbearable then I'll just be  
11                  quiet.

12                 We fix things. So Steve said something  
13                 that I want to make sure that as we talk about  
14                 what happened with the readmission measure so  
15                 people understand that there were two things that  
16                 led to the consideration of not adjusting. One I  
17                 found that had a really small impact, but really  
18                 importantly, the second was the sufficient  
19                 analysis which I think I've shared with the  
20                 committee before and I could do again. Which I  
21                 see as exactly the issue Dave just raised which is  
22                 how much does it look like hospital quality may be

1 the mediator of the remaining relationship between  
2 SES and the outcome?

3 And we found that the hospital seemed  
4 to be a bigger factor than the patient factor. So,  
5 it is as much a conceptual argument as it was sort  
6 of a small empiric results argument. So I think  
7 that's just for folks to understand about the  
8 readmissions group.

9 Two, a clarification about  
10 stratification. Christie -- I'm sorry if I got it  
11 wrong -- was saying we shouldn't focus just on  
12 stratification, that between hospitals is very  
13 very important. And I totally agree. And I think  
14 everybody on the committee agrees. I think there  
15 may have been a miscommunication. I think both  
16 things are important: understanding differences  
17 between plans or hospitals and within. And we use  
18 stratification to talk about both things, which  
19 can be confusing. Right?

20 So we can stratify the patient groups  
21 in our hospitals to understand the hospitals and  
22 if there are differences in the outcomes or the



1 processes for one group of patients in that  
2 hospital compared to another patient in that same  
3 hospital. That's a version of stratification  
4 within a hospital or a plan.

5 We also talk about advances in  
6 stratifying hospitals. Now we're looking at the  
7 hospital as an entity and a group of hospitals  
8 that are similar. That's a different kind of  
9 stratification. And that gets at more of the  
10 between-hospital question.

11 Two clarifications. I have a question  
12 for the group if you guys have bandwidth on -- on  
13 the community factors issue what we run up against  
14 is as you really choose kind of the community  
15 factor there is, as someone said, huge evidence  
16 that a patient's community affects their health.  
17 But if I'm going to account for that, I really  
18 have to do location because you know two hospitals  
19 can be co-located in the same community but one of  
20 them may have many patients that are coming from  
21 neighborhoods that affect health. And one of  
22 them, even though they live and they work in the

1 hospital's community, they have very few of those  
2 patients. So if I enter the same community for  
3 both those hospitals, I'm not capturing that  
4 neighborhood impact on an individual's health.

5 A different example is a case where a  
6 community has something like not very many nursing  
7 home beds. Now, both those hospitals are  
8 potentially equally affected by the gap in  
9 services in that community.

10 So I would love for the committee to  
11 give some thought about how you would handle those  
12 two very different kinds of community factors.

13 So back to you.

14 CO-CHAIR PONCE: Thanks, Susannah.

15 I'm not sure, did everybody -- I'm not  
16 sure we got 100 percent of what you said. But I  
17 got most of it. Thank you.

18 Yolanda.

19 MEMBER OGBOLU: Yes. I have been  
20 listening. And I was thinking about the community  
21 factors, specifically in the need to kind of learn  
22 a little bit more about it. I know that there is

1 a whole body of evidence out there.

2 And somebody had mentioned Anna Diaz  
3 earlier. And I also wanted to say we might want  
4 to consider learning more, too, from the work of  
5 Thomas LaVeist who is now at George Washington  
6 University. He did a study in Health Affairs that  
7 I found really interesting that actually compared  
8 black and white Americans who live under similar  
9 social and economic conditions, and also received  
10 healthcare in the same marketplace. And that  
11 study was done in 2011.

12 And it's really interesting because the  
13 racial disparity that we normally see in national  
14 samples was attenuated when people lived under  
15 similar conditions. And so they controlled  
16 actually for the community in which people lived  
17 in and focused a lot on place. And then also  
18 compared people that had healthcare in the same  
19 marketplace. And I just think that was very  
20 interesting, that sample strategy was to search  
21 for communities that had 35 percent African  
22 American, 35 percent white, and looked for people

1       that had similar median incomes, as well as  
2       graduation rates. And they were able to find 425  
3       different tracks across the country that met that  
4       inclusion criteria.

5               And then the study -- the paper in  
6       Health Affairs is really their first paper that  
7       compared two of these communities, that happened  
8       to be in southwest Baltimore. But there are  
9       experts out here on these community factors. And  
10      I think we could leverage that, having them  
11      perhaps come in and share more of what they know  
12      with the disparities -- Health Disparities  
13      Standing Committee.

14              CO-CHAIR PONCE: Great. Thank you,  
15      Yolanda.

16              Philip.

17              MEMBER ALBERTI: Yes. Thank you,  
18      Yolanda, for bringing up that study. That was --  
19      it's a great piece of work and I think it is  
20      important for this conversation.

21              And, Susannah, I don't know if I got  
22      everything. The connection was a little bit

1 scratchy, so forgive me in advance if I'm  
2 responding to something you actually didn't say or  
3 imply.

4 So, when I'm thinking about community-  
5 level factors, I'm not thinking about -- I'm not  
6 thinking about the community in which the hospital  
7 resides. I'm thinking about the community-level  
8 factors that patients bring with them to the  
9 hospital.

10 So in terms of two hospitals that are  
11 co-located in a different community with different  
12 patient mixes and different patient populations,  
13 trying to adjust for that community where the  
14 hospitals are, I'm much less interested in that.  
15 And I'm thinking about a poor patient who goes  
16 home to a wealthy neighborhood versus a poor  
17 patient who goes home to a poor neighborhood.

18 So when I was kind of hoping that we  
19 could think about ways to test some of these  
20 community-level factors I really meant the aspects  
21 of a community that individuals carry with them  
22 where variables are not necessarily defined by the

1 aggregation of patient-level variables, but really  
2 variables defined at a community level where the  
3 patients themselves are being discharged to.

4 CO-CHAIR PONCE: Thanks for the  
5 clarification.

6 DR. BURSTIN: So I'm getting the sense  
7 -- at least in terms of this issue -- that there  
8 is not broad agreement that we should proceed --  
9 at least for now -- on hospital factors as being  
10 the next potential way to bring in adjusters. But  
11 it sounds like just the overall sense of the  
12 conversation is that there is a great deal of  
13 interest, however, in exploring further the  
14 community factors.

15 And I have not heard anyone say  
16 anything to suggest that that would not be  
17 potentially a viable strategy, particularly I  
18 think as Philip just articulated it. But it's  
19 really about the patient in the community in which  
20 they reside, not the hospital in which they  
21 reside.

22 Does that sound on track for now?

1 CO-CHAIR PONCE: Yes.

2 DR. BURSTIN: Okay. Good, okay.

3 Kevin, were you going to say anything?

4 You were about to lift your thing?

5 MEMBER FISCELLA: I was going to say,  
6 I think as was implied, I think we do need more  
7 research in this area. We just don't have enough  
8 empiric data, I think, to make --

9 DR. BURSTIN: Yeah.

10 MEMBER FISCELLA: -- great, informed  
11 decisions here.

12 DR. BURSTIN: For both you think?

13 MEMBER FISCELLA: Well, particularly  
14 for the hospital.

15 DR. BURSTIN: Yes.

16 MEMBER FISCELLA: But even the  
17 community. I think there's even analytic  
18 challenges here that need to be worked out and  
19 modeled and understood better.

20 DR. BURSTIN: Yeah. And actually just  
21 raising that point, a point both Sarah and -- I'm  
22 sorry, that Susannah and Philip both raised

1 earlier as well, is what if you only have  
2 community data on a subset of patients, is that  
3 something still viable to consider as part of the  
4 modeling? Thoughts on that?

5 MEMBER RAUNER: Yeah, kind of a follow-  
6 up on Philip's suggestion. I think the problem  
7 right now is a lot of our data is driven by  
8 hospital because they're worried about getting  
9 dinged for the 30-day rule. The perspective of  
10 those studies was the wrong perspective for what  
11 we're looking at.

12 What was done based on a huge Medicare  
13 claims data set, which was looking at thousands  
14 and imputing ZIP Codes, I mean -- the studies and  
15 the data both started from the wrong direction.  
16 And I think what Philip's talking about, you need  
17 neighborhood-level factors. Just the fact that a  
18 hospital happens to be here, that's not the main  
19 issue. The main issue is what's the neighborhood  
20 like and what can be fixed in the neighborhood?

21 The hospital I think is the worst place  
22 to do population health. It's the neighborhood is



1 where you do population health. But everything  
2 seems to be driven by the hospital because that's  
3 where the money is, you know.

4 And so I think the problem is the  
5 research isn't there but probably because the  
6 perspective's been wrong from the start. But it's  
7 based around things like 30-day readmission rules.  
8 That's not why we're doing this stuff. Although  
9 there's a penalty and the hospitals are worried  
10 about that penalty, but I think we need to go back  
11 and do the data -- the right data for the right  
12 reasons so we can actually get this study.  
13 Because I think just the research isn't there  
14 because of that.

15 CO-CHAIR PONCE: Thanks, Bob.

16 Traci.

17 MEMBER FERGUSON: Yeah. Just to answer  
18 Helen's question about whether you could use a  
19 subset. I think that if you look at the subset of  
20 that population, if that aligns with or you could  
21 generalize the population that is treated at that  
22 hospital, whether you're looking at overall claims

1 data in terms of diagnoses, in terms of the use of  
2 community resources, that you should be able to  
3 use a subset of that population. Shouldn't say,  
4 you know, you want to be, you know, have enough  
5 power within that sample size in order to make,  
6 you know, make decisions, and to see if there's,  
7 you know, statistical power.

8 But I think that you should be able to  
9 use a subset. As long as they can show that there  
10 is a correlation of relationship so it does  
11 represent the overall population that's being  
12 treated at that facility.

13 CO-CHAIR PONCE: Yes, Helen, I wasn't  
14 really sure what you meant by subset. Do you mean  
15 like --

16 DR. BURSTIN: Earlier I think both  
17 Susannah and Philip had said sometimes you may  
18 have data on 10,000 patients in a community, but  
19 it may not necessarily be -- why don't you  
20 actually say what you meant?

21 MEMBER ALBERTI: Yeah. No, I have this  
22 fantasy, right? So here's my fantasy.

1                   It's a -- well, sorry, okay. Switch  
2 fantasies. Different.

3                   (Laughter.)

4                   MEMBER ALBERTI: Thank you for pulling  
5 me back. I appreciate that.

6                   You know, in New York City -- and, you  
7 know, they have a wealth of data, right? So they  
8 do a regional -- kind of local BRFSS. They call  
9 it a Community Health Survey. They take all the  
10 national data that CDC uses, add in a bunch of  
11 things that are really important to the New York  
12 City government and public health, and they over  
13 sample in all the neighborhoods and all the ways  
14 you'd want to over sample.

15                   So you can look at a prevalence map of  
16 risk factors based on kind of New York City  
17 defined communities. It has nothing to do with  
18 the ZIP Code, nothing to do with area, nothing.  
19 It's just really kind of local, you know, Little  
20 Italy versus Chinatown versus Bed-Stuy versus the  
21 South Bronx. What do you see? Where are the risk  
22 factors?

1                   And so, you know, I wonder, if there's  
2                   ever an opportunity when these variables come up,  
3                   to get a coalition of New York City hospitals  
4                   together, link it up with New York City Public  
5                   Health Department data that has really robust  
6                   neighborhood-level data on risk factors, just to  
7                   see in New York City does -- do these kinds of  
8                   adjustments make sense? When you add in both the  
9                   clinical risk adjustments, the patient-level risk  
10                  adjustments, and these comprehensive community-  
11                  level factors, what do you see?

12                 You know, so for me that's a more --  
13                 even though it's regional or, you know, a subset,  
14                 it's more satisfying than saying here's my  
15                 beautiful conceptual model. We're just going to  
16                 throw in, you know, black versus white and dual-  
17                 eligibles because that's all we have nationally.  
18                 Where you really don't necessarily -- you're not  
19                 testing what you think the relationships really  
20                 are.

21                 CO-CHAIR PONCE: Yeah. I think that's  
22                 -- I share that fantasy. So because I think it is

1 more about local, or doesn't have to be the  
2 federal/national data sets that have, as we saw in  
3 one of the reports cards that we saw, had so many  
4 missings. But if there are data systems that get  
5 more at community-level effects, that those should  
6 be considered.

7 MEMBER ALBERTI: And it gives us an  
8 opportunity to make a case for new data systems to  
9 come online, new data collections, you know, to  
10 begin. Because when you have these local analyses  
11 you say, well, actually, yeah, that does make a  
12 difference. And we do have -- as someone on the  
13 phone, David, said -- fairer, more accurate, more  
14 valid depictions of the quality of various  
15 hospitals.

16 CO-CHAIR CHIN: Yes. It's the  
17 equivalent of Christie's analyses she showed us,  
18 which are more detailed data sets.

19 And I wonder, Helen, could you tell us  
20 a little bit more about -- you mentioned the  
21 hospital letter to NQF. Could you tell us a  
22 little bit more about their concerns?

1 DR. BURSTIN: Some of them were more  
2 process concerns. And I wasn't sure if we had  
3 sent that out in advance.

4 But some of these issues of what's a  
5 conceptual basis, why haven't you considered  
6 factors beyond what we have found so far in terms  
7 of patient-level factors -- and actually I can  
8 pull it up to see if there's anything else.

9 And we're happy to share that with you  
10 guys after the fact. But just concerns about, you  
11 know, there have been a lot of unanswered  
12 questions through the course of the 2-year trial.  
13 You know, when do those get resolved?

14 And, in fact, their recommendation was  
15 that NQF continue the trial.

16 Philip, I don't know if you want to say  
17 anything further since AAMC was one of the  
18 signatories? Or let's just show the letter  
19 afterwards. That's fine.

20 But because there are so many  
21 unanswered questions without a lot of clarity on  
22 some of these issues, some of our standing

1 committees have been forced to make decisions  
2 maybe not with a full array of some of this  
3 information. So we'd be delighted to share it  
4 with you as we move forward.

5 Well, you know, the next discussion  
6 item is actually just to walk through our  
7 evaluation plan for the trial period. And, again,  
8 if some of these issues come up we can try to  
9 address them as part of the evaluation as well.

10 Should we transition maybe to the --

11 CO-CHAIR PONCE: Let me just check.

12 I'll just check with those on the phone  
13 if you have any comments before Helen goes to the  
14 next set of questions.

15 (No response.)

16 CO-CHAIR PONCE: Okay.

17 DR. BURSTIN: So we'll think about a  
18 process to bring those other unresolved issues to  
19 you so we can tee them up and have further  
20 discussion on them.

21 If you think of other unresolved issues  
22 as we come through this discussion over the next

1 45 minutes to so, please let us know as well.

2 So with that, next slide.

3 Let's talk a little bit about where we  
4 are in terms of the evaluation for the trial  
5 period.

6 So, next slide. Just some background.  
7 And, again, many of you have been around this  
8 block with us for a very long time. And we thank  
9 you for that. It's been a very long block.

10 We, back in April of 2015, began a 2-  
11 year trial period of a change in policy, temporary  
12 change in policy that would allow risk adjustment  
13 of measures for SES and other demographic factors.  
14 This was the committee led by Kevin and Dave. And  
15 many of you around the table were on it as well.

16 And so prior to this we had actually  
17 not allowed social risk factors, SES kind of  
18 factors as part of risk adjustment for fear of  
19 actually masking disparities. It was actually  
20 written explicitly into our validity criterion  
21 that we would not allow these measures -- these  
22 factors to be included. And we only allowed for



1 patients' clinical factors present at the start of  
2 care.

3 As part of the trial period, after the  
4 report came out, we suspended that prior policy,  
5 and have now implemented as part of this trial  
6 basis that measures can be adjusted for SES and  
7 other -- I was hitting the next slide; I turned  
8 off my mike.

9 So, during the trial period we  
10 instructed each of our standing committees to  
11 evaluate each individual measure as recommended by  
12 the report. This was not a blanket assessment  
13 that said all measures should be adjusted, it was  
14 to be adjusted if you met a certain bar, to  
15 consider those factors.

16 And we required that the measures --  
17 the committees in fact considered both the  
18 conceptual basis, the logical model of the  
19 evidence of why you would potentially look at that  
20 variable for that measure, as well as the  
21 empirical data analysis to show whether those  
22 variables were in fact related to selected risk

1 factors.

2 If SDS was determined to be appropriate  
3 for a given measure, as I mentioned briefly  
4 earlier, we endorsed one measure that has  
5 specifications for both the adjusted measure as  
6 well as specifications to get at the stratified  
7 measure, to get at that transparency issue.

8 Next slide.

9 So, when we formed this Disparities  
10 Standing Committee we gave it a very broad charge.  
11 And some of that was promising. But people who  
12 really wanted us to have, and for myself as well,  
13 a real cross-cutting emphasis for all of NQF's  
14 work around disparities, the work on our roadmap  
15 which we spent the last couple of days talking  
16 about, but also very specifically put in the  
17 charge of this committee to review implementation  
18 of the revised NQF policy regarding risk  
19 adjustment for SDS factors, and to help us  
20 evaluate the trial period.

21 Next slide.

22 So, at this point we have now asked all

1 the committees, as all measures are coming through  
2 -- and as I mentioned earlier, we for the most  
3 part have asked them to consider specifically  
4 outcome measures where there was a risk adjustment  
5 model. But I will tell you as part of even some  
6 of the conceptual discussions, some process  
7 measures and some intermediate outcomes have been  
8 raised at least on terms of a conceptual basis.  
9 And we will bring that data forward to you.

10 And, in particular, the readmission and  
11 the cost resources measures were endorsed with the  
12 condition that they actually go through the trial  
13 period. And those were explicitly included as  
14 part of the trial. But, literally, all outcome  
15 measures that came in we had a special form as  
16 part of this trial period that all developers ad  
17 to complete around conceptual basis. And, if yes,  
18 the committee then would indicate, yes, we'd like  
19 to see the empirical analysis, and the empirical  
20 analysis done as well.

21 Next slide.

22 So, we have certainly, as is

1 highlighted, a lot of challenges. Not  
2 surprisingly. We've been talking about them for  
3 two days. Numbers 1, 2 and 3 are data, data, and  
4 data. Certainly it has been a challenge.

5 And we've had a lot of outcome measures  
6 actually submitted. I don't know what the final  
7 numbers will be. It's literally ending in April,  
8 so we're going to get all these data to you by  
9 June -- before June, so you can review it before  
10 the in-person meeting.

11 We have had many of them who clearly  
12 have a conceptual basis, where you would look at  
13 the prior evidence, you would look at the outcome  
14 measure in question, and you would say, Hmm, that  
15 looks like a measure that potentially should be  
16 adjusted for social risk. But generally, the  
17 empirical data have not supported that and have  
18 generally not led to inclusion of those factors in  
19 those endorsed models.

20 And we have continued to try to monitor  
21 progress on anything we can do in this feel. So,  
22 for example, Karen Joynt has been incredibly

1 generous of her time and presented the full ASPE  
2 findings, for example, to our Consensus Standards  
3 Approval Committee, to our Measures Application  
4 Partnership, to you, to make sure we know what's  
5 going on. We shared all the NAM reports as best  
6 we can as well.

7 So next.

8 So, you have all seen this. We talked  
9 about this again today. This is the big issue we  
10 just continue to face in terms of what's available  
11 versus not available. I think this slide got a  
12 little oddly oriented. But much of what we have  
13 seen, really as Philip just pointed out, has been  
14 a focus on dual-eligibility, some data using the  
15 AHRQ deprivation index, and then some information  
16 on black/white race.

17 Although each time that has been  
18 brought forward the argument has been it's not  
19 been brought forward as a proxy -- and we've  
20 talked about this in the committee for SES -- but,  
21 instead, because in fact some of those differences  
22 are larger than what we're finding in terms of

1 social risk factors, the developers, in particular  
2 Yale, thought it was important that people  
3 actually see those differences. But we have not,  
4 for example, seen any of the sort of further  
5 evidence for our neighborhood deprivation or any  
6 of these other community-level factors.

7 Next slide.

8 So, we're going to end this. At least  
9 the initial two-year trial ends in April. We had  
10 an initial evaluation plan way back when, when our  
11 report first came out. And we are currently at  
12 the point of almost being done. I think Drew and  
13 Erin are helping to do this, with Karen Johnson,  
14 our lead methodologist, of gathering information  
15 from all committees over the last two years with  
16 all measures submitted to us, to see which  
17 measures are submitted with adjustment, the ones  
18 that may have had a conceptual basis, but then the  
19 empirical basis didn't support it.

20 And then, specifically when we go to  
21 those analyses, what issues were raised in terms  
22 of which SDS factors were put in the model --

1 we'll actually be able to share with you back --  
2 which factors were considered, which factors were  
3 raised by committees that were not available, and  
4 the kind of information you've seen across all of  
5 those submissions.

6 About how many have we seen, Erin,  
7 total?

8 MS. O'ROURKE: It depends a little bit  
9 how you count some of the survey measures.  
10 Probably around 10 with the various measures.

11 DR. BURSTIN: No, no, the total number  
12 that we looked at. You haven't done the math?

13 MS. O'ROURKE: We haven't done the  
14 math, but hundreds.

15 DR. BURSTIN: Hundreds is what I was  
16 going to suggest.

17 Okay, next slide, please.

18 So, as we've looked at it, our approach  
19 has been thinking about a couple of key questions  
20 to explore. And, again, this is we're still in  
21 the midst of doing the data collection. So this  
22 is an opportunity for you to say are these the

1 right questions? Are there additional data  
2 elements we could be gathering as part of this  
3 work?

4 So, first, is are these factors having  
5 a significant effect on the outcomes being  
6 assessed?

7 If it's a strong relationship are we  
8 finding the empirical relationship? Why or why  
9 not? I mean, for example, the issue just raised  
10 about multi-level analysis, are they using those  
11 strategies? I mean, those are the kinds of things  
12 we could try to tease out as part of this work.

13 Which factors and variables are being  
14 used?

15 What are the critical data gaps that  
16 have been identified each time these measures have  
17 been brought forward?

18 Next slide.

19 We are also going to try to, in  
20 addition to just collecting what's been done to  
21 date, our thought is we are going to actually  
22 survey both measure developers who have had to do



1 the work with filling out these forms and giving  
2 us their information and trying very hard to find  
3 data -- to give us some more qualitative  
4 information.

5 We're also going to do a survey of all  
6 of our standing committee members -- we're talking  
7 across about 10 or 12 different standing  
8 committees who have looked at this over the last  
9 two years -- to get their perspectives on some key  
10 issues like, for example, how difficult is a cost  
11 burden, just overall difficulty to comply with the  
12 new requirements to collect, to provide  
13 information on social risk?

14 How effective have we been -- really a  
15 report card on NQF -- in terms of the materials we  
16 have provided to developers, to standing committee  
17 members? Are they feeling like they had enough  
18 information to make some of those decisions?

19 And certainly it's been a work in  
20 progress. So sometimes questions come up at these  
21 tables, not surprisingly. That's a really good  
22 question. We'll go to the Disparities Committee

1 and get back to you.

2 But, you know, and then finally, did  
3 the committee members feel like they had all the  
4 information they needed? What else would they  
5 have wanted to know as they looked at the question  
6 of adjustment, and what other information would  
7 have been valuable?

8 We'll also -- and Erin and Drew will  
9 help us do this -- in particular, we have a very,  
10 very rich database of all the public comments  
11 submitted on all these measures over the last two  
12 years, so we'll also do some qualitative analysis  
13 of the comments submitted, to get a sense of what  
14 people are saying about their concerns around  
15 adjustment and the variables used in data, et  
16 cetera.

17 Next slide.

18 So, that's where we are. Just to give  
19 you a sense of the timeline -- and we'll go back  
20 to those questions in a moment -- today you've had  
21 a chance to at least hear a little bit about where  
22 we are, thinking about the evaluation plan and

1       some of those unresolved issues.

2                   At your June meeting we have a lot of  
3 work to do. But we have again carved out time --  
4 I think it's half a day -- to do, for us to  
5 present the results of the trial period  
6 evaluation. You'll help us review that  
7 evaluation, offer further input to NQF. We'll  
8 then bring it to the CSAC, the Consensus Standards  
9 Approval Committee, just a little bit less than a  
10 month later. They are the group that looks at  
11 NQF's criteria. And since validity is one of  
12 them, will again offer their input.

13                   And then July 20th, NQF Board of  
14 Directors will look at all this collected input,  
15 along with NQF leadership, and help us think  
16 through the future policy directions in terms of  
17 how we want to move this forward.

18                   So that gives you sort of the lay of  
19 the land. And we can go back to the key  
20 discussion questions, if you guys could.

21                   It's the next one. Next one. Perfect.  
22 And let's just stop there.

1                   So, again, your detailed comments, your  
2 sort of overall conceptual comments, all open.

3                   CO-CHAIR PONCE: Nancy and then Bob.

4                   MEMBER GARRETT: Well, I just want be  
5 sure, Helen, we answered your question about the  
6 conceptual basis or if people are maybe wanting  
7 some more guidance there. And I just have a  
8 thought about it.

9                   So being on the Cost and Resources  
10 Committee I've kind of seen a little bit of how  
11 this has worked in the last couple years. One of  
12 the challenges with the conceptual basis is that  
13 what I notice the measure developers doing is  
14 doing a literature search. And there's just not  
15 a lot of good research yet on a lot of these  
16 issues.

17                   And so that, I think that's not --  
18 that's important but it's not enough. It's really  
19 what is the logic model of how this outcome  
20 measure -- what influences those arrows that Dave  
21 was talking about? They'll be able to tell you  
22 about what are all the things that influence this

1 outcome measure other than clinical process of  
2 care and do we need to be accounting for those.

3 So I just wonder, as one possible  
4 suggestion, and this might be me not quite  
5 understanding how the process works, but it seems  
6 to me as a standing committee member that usually  
7 that conceptual question happens when we're  
8 reviewing the measure and I'm looking at the  
9 submission from the measure developers, so it  
10 seems like the burden is really on them to figure  
11 out that conceptual basis.

12 And I wonder if another approach would  
13 be to have the standing committee play more of a  
14 role there, and go to them early on and say based  
15 on all the expertise of the standing committee is  
16 there a conceptual basis for this measure or not?  
17 And what should we be requiring the developers to  
18 look for.

19 So, just a thought.

20 DR. BURSTIN: And, actually, in terms  
21 of the evaluation plan it keys up for me that  
22 something we should look at is also what was the

1 source of the conceptual model feature of the  
2 measure submitted to us. So, thank you, that's a  
3 great suggestion of whether when it's pure  
4 literature versus conceptual basis, by whom, based  
5 on what. Great.

6 CO-CHAIR PONCE: Bob.

7 MEMBER RAUNER: Quick kind of a request  
8 to go study some of the really big ones. So,  
9 like, right now there's something like 600  
10 Medicare Shared Savings ACOs right now, and it  
11 turns out that a lot of commercial plans and even  
12 MIPS, they're all using a lot of some of the same  
13 big measures. But we don't have, we don't have --  
14 nobody's looked at those in the same way they've  
15 looked at the 30-day Readmission Rule.

16 So, can we take diabetes poor control,  
17 blood pressure control, breast and colon cancer  
18 screening, which are big impact measures within  
19 that, and then apply the same type of effort that  
20 was put into looking at whether the 30-day  
21 Readmission Rule should be addressed or any of  
22 that. So because I'm pretty sure there's very big

1 differences. And I think we are going to see that  
2 people get dinged inappropriately.

3 So I think, you know, unfortunately I  
4 think this means it's three to five years from now  
5 before we'll get the answer probably. But I think  
6 we really need to start looking because that's  
7 going to start driving healthcare so much in the  
8 next couple years, with so many ACOs, commercial  
9 plans, all using the same measures and MIPS.  
10 Everybody's kind of jumping into that bandwagon  
11 now, and we need to know how often, you know, my  
12 ACO could get dinged on a quality measure because  
13 of where we are, and pulling in some of Philip's  
14 neighborhood-level factors.

15 I don't know how to get there, but I  
16 think it's like they need to start putting some  
17 big RFPs to do studies on this or something.

18 MEMBER NERENZ: Dave here real quickly.  
19 Sorry to jump the queue. It's real hard from the  
20 phone.

21 Certainly support Nancy's comment, and  
22 also I agree that the whole MIPS domain is going

1 to be important. I've got a paper that just came  
2 out that sort of speaks to that from kind of one  
3 perspective. I can attach that and send it around  
4 to the group, if you're interested in that.

5 CO-CHAIR PONCE: Yes. Thanks, Dave.

6 Philip.

7 MEMBER ALBERTI: Yeah, just to follow  
8 up on Nancy's point. I thought it was a great  
9 point. And I wonder if, you know, given the  
10 domains that we've come up with and the  
11 subdomains, and thinking through this much broader  
12 kind of framework, if we're thinking about health  
13 equity measurement, I wonder if there's an  
14 opportunity proffered by this in a broader  
15 framework that we're developing to actually pick  
16 measures that we think are equity-sensitive,  
17 disparity-sensitive, tie them to the subdomains  
18 that we are delineating under these larger  
19 domains, and walk through what we think, as a DSC,  
20 the conceptual model is; why that's a disparities  
21 or an equity-sensitive metric; where we think some  
22 of the, you know, patient-level, community-level



1 influences are.

2 I think we could maybe weave that into  
3 our final report a little bit more to offer some  
4 guidance and be more proactive.

5 CO-CHAIR CHIN: So I'm sort of thinking  
6 like the overall mission and then this issue of  
7 like trying to do good, and then the different  
8 stakeholders, and this critical gap area, and I  
9 can see ourselves, like, spinning our wheels for  
10 a while in the sense that, well, adequate data  
11 systems do not exist nationally so we can't test  
12 nationally then whether or not that these social  
13 factors matter. And with the crude variables to  
14 date, most of the time they don't seem to matter.

15 However, we have some studies with  
16 finer data sets like Christie's, and it does seem  
17 that when you have -- benefits it does -- social  
18 factors do matter more. But we're not going to  
19 have, like, that exist for a while. But I'm  
20 wondering if part of I guess the solution may be  
21 we have this latitude then to make other  
22 recommendations. So, I mean, right now, for

1       example, we're seeing that, well, yeah, we should  
2       keep on doing the trial period, we need better  
3       data sets.

4               What Nancy and Philip said, that makes  
5       a lot of sense, with data sets that we might  
6       provide more guidance to measure developers. So,  
7       I mean, there's 100 measures developers submitting  
8       guidelines, we struggle so much with this, it's  
9       probably highly variable the quality approach that  
10      the 100 developers took.

11             But then we have this other thing about  
12      like the other policy leverage we can recommend.  
13      So, for example, if the concern is then like the  
14      safety net that it's getting dinged for caring for  
15      those populations, well, we can think about them  
16      like the -- as part of the report might be then,  
17      well, because it's going to take years to get the  
18      data sets, we need to think of some of the other  
19      options available then to supply additional  
20      support so they don't get unfairly penalized.

21             CO-CHAIR PONCE: Great. Thank you.

22             Kevin, and then I'm going to go to the

1 phone.

2 MEMBER FISCELLA: So the first  
3 question, does risk factors have effect on the  
4 outcome of the measure? I think it's important to  
5 clarify what we mean by outcome. Because  
6 oftentimes even in these models -- and Susannah  
7 can correct me if I'm wrong -- but you will see,  
8 you will see a statistical effect. It may be very  
9 small and you may have an odd ratio of 1.1, 1.2.

10 So there is a, there is an effect  
11 between the SDS factor and, you know, that outcome  
12 readmission. But what you don't see is as much  
13 effect on the total variance explained. And it  
14 may have a minimal effect sometimes on the actual  
15 ranking.

16 So, so depending on what you mean by  
17 significant effect I think you might get different  
18 answers. And I think it's important to  
19 distinguish those.

20 DR. BURSTIN: That's a great point,  
21 Kevin. And you tee up another issue that has come  
22 forward which is that, you know, we'll say

1 significant effect -- and Susannah can certainly  
2 speak to these -- some of these variables that  
3 have been put in their models, for example for  
4 duals, are significant, but the effect size is  
5 really small. And one of the issues that's often  
6 brought up is, well, we're saying it's not an  
7 effect overall, but are there certain -- you know,  
8 again as we think about this in the context of  
9 public reporting and payment -- are there some  
10 potentials within that distribution for whom even  
11 that small effect could have a significant impact?  
12 And how do we factor that into our thinking about  
13 adjustment?

14 CO-CHAIR PONCE: Similar to what  
15 Christie was also saying in terms of which groups  
16 --

17 DR. BURSTIN: Right.

18 CO-CHAIR PONCE: -- we would budge for.

19 Susannah, I hope you can still speak.

20 I know you're on the train, but.

21 MEMBER BERNHEIM: I am on the train.

22 I'm going to speak slower and hope you can hear me

1 a little better.

2 But I mean I think people are raising  
3 interesting questions. I don't actually have that  
4 much to add. We think about all of these issues,  
5 obviously, as we're bringing the measures forward.  
6 And I'm happy to speak to that experience. But I  
7 think great questions are being asked.

8 CO-CHAIR PONCE: Great. Thank you.

9 And, Yolanda?

10 MEMBER OGBOLU: I have no additions as  
11 well.

12 CO-CHAIR PONCE: Thank you. And Dave.

13 MEMBER NERENZ: I'm okay.

14 MEMBER BERNHEIM: Sorry. This is  
15 Susannah.

16 I have one small thing based off what  
17 Dave had said earlier.

18 CO-CHAIR PONCE: Okay.

19 MEMBER BERNHEIM: Which is I think that  
20 this question of how quality figures into  
21 disparities is not always incorporated into the  
22 conceptual models. And it's a really key

1 conceptual question. So, this is sort of a micro  
2 point, but if we're going to give more guidance,  
3 part of our guidance might be not just about data  
4 and empiric analysis, but I think we could also  
5 give better guidance on thinking about where  
6 quality fits into conceptual model.

7 CO-CHAIR PONCE: Great. Thank you.

8 I think you mentioned a little bit  
9 about that, where you thought quality mediated the  
10 SES factors in your previous comment.

11 Kevin.

12 MEMBER FISCELLA: Yeah, one other point  
13 related to this. That if I were CEO at an inner-  
14 city hospital, I could see where I might be  
15 worried even if the overall effect on the variance  
16 and the ranking on any one particular measure was  
17 really small, if I'm being evaluated on, you know,  
18 200 different measures, and the effect of SDS is  
19 pretty consistent across this, but, you know, you  
20 may get a cumulative effect. And some may be  
21 larger than others.

22 And, you know, I wonder if that's part

1 of the angst that you're hearing from the American  
2 Hospital Association that even if, even if these  
3 changes are relatively small, in aggregate over  
4 time with enough measures they may be more  
5 significant.

6 CO-CHAIR PONCE: Thank you. Emilio.

7 MEMBER CARRILLO: Yeah. Just to point  
8 out a potential confounder is in those patients  
9 that are at highest risk in most hospitals will  
10 get a services, a care manager, patient navigator,  
11 a lot of attention. So that creates another  
12 variable that we're not really looking at that can  
13 impact the very small changes that we're seeing.

14 CO-CHAIR PONCE: I think that's a very  
15 good point. In the SDS Risk Adjustment Group we  
16 had some membership from FQHCs that had a lot of  
17 enabling services. And so they weren't seeing any  
18 -- they were looking at LEP, limited English  
19 proficiency, as a social factor and they actually  
20 weren't showing any differences in care within,  
21 within the FQHC, and that's because there's a lot  
22 of enabling services.

1 I think that that's the unmeasured  
2 intervention mediating effect and could show that  
3 there's no relationship, although these clinics  
4 are actually doing something really good.

5 DR. BURSTIN: Yes. And they're  
6 expensive, too.

7 CO-CHAIR PONCE: And they're expensive.  
8 And they're not remunerated in some cases.

9 DR. BURSTIN: Yes. Sometimes they may  
10 be remunerated for FQHCs but not practices, not  
11 FQHCs in same communities.

12 CO-CHAIR PONCE: Not FQHCs, right.  
13 Right.

14 And Philip, if I call on your  
15 suggestion of equity-sensitive measures I think is  
16 a good one. I think it's what I think the ASPE  
17 folks also suggested we could do. I think we  
18 should proceed with caution, though, because it  
19 becomes a catch-22 with data, because if we don't,  
20 we may miss important health-equity sensitive  
21 measures because there is no data on that. So  
22 then we might miss out a whole -- when we start



1 narrowing we may miss out on interventions that  
2 may actually be needed that are unmeasured.

3 Philip.

4 MEMBER ALBERTI: Yes, I agree. And I  
5 don't think it -- it certainly shouldn't be our  
6 job to define all equity-sensitive metrics. But  
7 I think we, given some guidelines on how to assess  
8 and build conceptual models based on metrics that  
9 are currently in use, that we do think there is  
10 conceptual basis for, why we think that, et  
11 cetera, as a set of guidelines.

12 And to respond to Kevin's, you know, I  
13 think, you know, part of the concern is not even  
14 measuring the aggregate, given the research that  
15 Christie was talking about, even just one metric  
16 that moved some of the hospital in the middle. It  
17 might be a small effect size, although it's  
18 statistically significant. But that small effect  
19 size still translates to dollars.

20 And I think part of the other piece is  
21 that even kind of the small effect size of the  
22 social risk factors notwithstanding, there's still

1 a larger effect size in some of the clinical risk  
2 adjustments that are kind of rather  
3 uncontroversial. And so I think it's just a per  
4 organization and understanding what is a  
5 statistically significant finding, a clinically  
6 significant finding, a monetarily significant  
7 finding? And I think there are different  
8 definitions.

9 CO-CHAIR PONCE: Thank you. Emilio.

10 MEMBER CARRILLO: Yes, to the equity  
11 sensitive factors. A while back we went through  
12 a whole exercise on culturally competent sensitive  
13 factors, developed a whole logic model, and  
14 basically came out with different categories for  
15 sensitivity. So since there is some, there is  
16 such interfacing between cultural competence and  
17 equity, we could look at that for some, some  
18 foundation.

19 DR. BURSTIN: And some of the work, I  
20 think Marshall even co-chaired when we did the  
21 work around disparity sensitivity before. We'll  
22 be bringing back to you for reconsideration and

1 maybe tightening some of that up. But I actually  
2 prefer equity sensitivity than disparity  
3 sensitivity actually. Bringing it as a way of  
4 positive instead of negative. That's interesting.

5 CO-CHAIR PONCE: Thanks, Emilio.

6 Oh, Christie.

7 MEMBER TEIGLAND: Yes, I just wanted to  
8 reiterate what Philip said. And I've been sitting  
9 here thinking that, you know, the overall  
10 aggregate weight coefficient odds ratio might be  
11 pretty small, but the effect on some plans is 20  
12 or 30 points in the ranking. Right? It can be  
13 huge on some of those plans in the middle.

14 And as I said, in both directions.  
15 Some plans can look far worse and some plans can  
16 look far better. So, you really can't just look  
17 at that coefficient that's looking at the whole  
18 aggregate population that you developed the  
19 measure based on.

20 And the other thing is the cut points  
21 that CMS uses, for example, for four -- two,  
22 three, four, five stars -- right -- are very, very

1       tight for some measures, like medication adherence  
2       measures. Those measures have cut point ranges of  
3       two or three points to go from a 3-star to a 4-  
4       star to a 5-star because they're very, very tight.  
5       Everybody does pretty darn well on medication  
6       adherence. So a tiny difference can make a huge  
7       difference in those plans and the ability for them  
8       to be 4-star and get those bonus payments.

9               So it's not trivial.

10              DR. BURSTIN: One of the questions --  
11       Susannah teed this up earlier and I'm not sure we  
12       could all hear her on the phone -- but one of the,  
13       I think, compelling issues that came up at least  
14       as part of the readmission measures was the  
15       analysis Yale had done on the decomposition  
16       analysis that showed that part of what was left  
17       was in fact weighted on hospital factors.

18              So, you know, again, insights here for  
19       what you could potentially offer to our committees  
20       or how to consider analyses like that, how to  
21       consider different kind of statistical modeling  
22       even, that could -- I mean that's one of the

1       unanswered questions, I think. As we've seen  
2       different developers come forward with different  
3       approaches, sometimes finding significant effect,  
4       sometimes not, how much of that is driven by the  
5       data, how much of it is driven by the outcome,  
6       whether there's a large effect? How much of it is  
7       driven by the statistical approach? And how much  
8       of it is driven by just some of these a priori  
9       assumptions going into the modeling?

10               So, your guidance here would be very,  
11       very helpful for us as well.

12               MEMBER TEIGLAND: And if you do the  
13       decomposition analysis so you're just analyzing  
14       that disparity, not the overall population, you do  
15       see those effects being much larger. So the  
16       decomposition analysis gets you, you know, a lot,  
17       buys you a lot more in terms of really seeing the  
18       impact, the full impact of those effects.

19               CO-CHAIR PONCE: Thanks. Bob.

20               MEMBER RAUNER: Along the lines with  
21       the hospital, there may be a way to run like a  
22       sensitivity analysis for a Medicare shared savings

1 program, ACOs, and hypotheticals. So like, say,  
2 it's a plan with 10,000 patients, \$80 million in  
3 Medicare costs, if this plan's quality measures  
4 because of their sociodemographic breakdown their  
5 measures are 5 percent lower, how many points does  
6 that mean they lose? And if they should get  
7 savings, what does that cost to them?

8           You might actually find out that what  
9 might be somewhat small differences like let's say  
10 your colon cancer screening rate was 65 percent  
11 versus 75 percent, how many points do you lose and  
12 how does it affect your calculation? It could end  
13 up being something fairly trivial or it could be  
14 something that costs an ACO hundreds of thousands  
15 of dollars such that if this ACO happens to work  
16 in an environment that's challenging versus, you  
17 know, working in a wealthy neighborhood, how would  
18 that affect them?

19           I think it's possible you could kind of  
20 run through some hypotheticals because those point  
21 scoring systems are all published, all out there,  
22 it's something you could put into analysis and

1 figure out. Because I think it's, you know,  
2 within the hospital, you know, dropping 20 points  
3 on that you could be talking millions of dollars.  
4 It may sound like it's 0.13 percent, but what does  
5 that really end up meaning at the end of the day?  
6 And so does that ACO that serves, you know,  
7 Hennepin County, does it lose hundreds of  
8 thousands of dollars of funding because of this?

9 I think that's where this could help at  
10 the ACO level just like applied at the 30-day  
11 readmission penalty level.

12 CO-CHAIR PONCE: Great. Thank you.

13 MEMBER BERNHEIM: Could I say one thing  
14 about the Medicaid adherence issue.

15 CO-CHAIR PONCE: Sure. Go ahead,  
16 Susannah.

17 MEMBER BERNHEIM: I'm hesitant to raise  
18 this, but it's one that gets at me every time it  
19 comes up, and so I just want to use it as an  
20 example of where what I hear that the empiric data  
21 is strong, but I worry a lot about the conceptual  
22 model because I feel like there's pretty good

1 evidence what we do as physicians influences  
2 adherence. And if we are seeing plans with more  
3 patients with adherence, I would want first to  
4 look deeply at whether we're thinking about what  
5 they can afford and what kind of medication  
6 regimen we're putting them on and how we're  
7 checking in about the situation.

8 And I worry that, in fact, in that case  
9 what I think it is doing us more harm. It may  
10 help the plan but I feel like it may be exactly my  
11 concern about us not deeply thinking about a  
12 conceptual model and their quality and our actions  
13 feed into those disparities.

14 So just food for thought.

15 CO-CHAIR PONCE: Okay, thank you.

16 It sounds like a lot of what we're  
17 heard, Helen is for moving forward. Not  
18 necessarily because, I mean, the trial's done or  
19 will be done soon, and so we did ask for  
20 sensitivity analysis. We did ask for looking at  
21 what significance means, not just statistical but  
22 clinical and payment indications.



1 DR. BURSTIN: Yes, this was great  
2 input. I think as we start pulling the data  
3 together to bring you in June we'll start maybe  
4 pinging a lot of Ninez and Marshall to make sure  
5 we present it in a way that's most useful. I've  
6 heard a lot of great things we could do. But I'm  
7 not sure they're directly related to the  
8 evaluation of the trial. But I think they are  
9 more a question of what we do next, do we build  
10 some of this in.

11 I do think it would be really  
12 interesting to build in maybe a couple of case  
13 examples of if you took a particular area and you  
14 tried to walk it through a full conceptual model  
15 and you look at the data available, maybe just  
16 even a couple of case examples might make it  
17 really useful, I think for the evaluation  
18 discussion in June.

19 CO-CHAIR CHIN: Down memory lane. I  
20 remember there was a Lisa Iezzoni paper from maybe  
21 15 years ago, JAMA paper, hospital mortality.

22 MEMBER IEZZONI: More than that.

1 CO-CHAIR CHIN: Yeah. So the same  
2 story, like five different risk adjustment models,  
3 depending upon which model you used the rankings  
4 of individual hospitals changed quite  
5 dramatically. But it shows, I guess, the  
6 practical implications then of your choice of  
7 different models and then the value judgments you  
8 make with each model.

9 MEMBER IEZZONI: I think it was more  
10 like what Christie said. That it didn't change  
11 that dramatically, but for some in the middle it  
12 might have.

13 DR. BURSTIN: Could you say that into  
14 your microphone?

15 MEMBER IEZZONI: I've said enough.

16 MEMBER TEIGLAND: She said, yes, what I  
17 said.

18 DR. BURSTIN: Those on the phone, she  
19 said what Christie said.

20 MS. O'ROURKE: I think now we are going  
21 to shift gears again a little bit and talk to you  
22 and get some input about the upcoming

1 environmental scan for measures that we'll be  
2 performing. So Drew's going to give some  
3 background about what that's going to cover and  
4 some areas we need some guidance from the  
5 committee.

6 DR. ANDERSON: Sure. So this really  
7 ties into the next steps and the purpose of the  
8 third interim report.

9 So, now that we've discussed some of  
10 the important areas for measurement we plan to  
11 use, once we have synthesized everything and, you  
12 know, and once you have submitted your homework we  
13 will be using the domains of measurement to do  
14 this environmental scan to see what the landscape  
15 of performance measures and measure concepts look  
16 right now. So, how can we map existing measures  
17 or best practices to these domains of measurement?

18 And so, for our approach we will follow  
19 a similar approach to what we have been doing in  
20 terms of looking for evidence. We will be doing  
21 a literature review, but mostly focusing on  
22 measure repositories. So ones that you all are

1 already familiar with, so like the health  
2 indicators warehouse, the CMS measures and  
3 inventory, the AHRQs and, of course, our own  
4 measure database.

5 We will also be conducting a couple key  
6 informant interviews with other committee -- the  
7 co-chairs of other committee members within the  
8 target conditions that we've been looking at so  
9 far, just to get a little bit more insight about  
10 what measures might be most important to include  
11 in the scan. Because these measures are really  
12 supposed to represent what rises to the top and,  
13 hopefully, the best of what is available.

14 And I think Helen mentioned this a  
15 little bit earlier, we plan to use a modified  
16 version of the NQF's disparity-sensitive criteria  
17 that was developed back in 2012. It doesn't quite  
18 fit perfectly but there's a lot of lessons that we  
19 plan to learn from when developing our approach.  
20 So really there are two tiers to this. And I'm  
21 not going to go into too much detail because we do  
22 have to kind of adapt it to this project because

1 it goes beyond some of the risk factors that they  
2 looked at originally.

3 But like the first year, just for  
4 example, the prevalence is really looking at the  
5 level of or whether or not the conditions is  
6 important for disparity. So we already have a set  
7 of conditions that we're looking at. Also, the  
8 quality gap is there, large disparities for --  
9 that the measure can detect, and then the  
10 potential impact.

11 But and then there are also the  
12 criteria.

13 So, again, I'm not going to go into the  
14 detail of this, these criteria, but we can share,  
15 if we haven't already, share the report from 2012  
16 for you to look through.

17 CO-CHAIR CHIN: Just to clarify then,  
18 Drew, that's like the third part here is the map  
19 to a practice which the closest to like the past  
20 two day's work would be mapping like to the  
21 different domains that were mentioned.

22 DR. ANDERSON: Right.

1 CO-CHAIR CHIN: So is that part of the  
2 test then to see -- of all the stuff we talked  
3 about, like, during the past couple days, these  
4 different domains, what measures, if any, exist  
5 then for these specific areas?

6 DR. ANDERSON: Right. So we would look  
7 at the interventions that are within the domains  
8 that you've identified. And for the ones where  
9 there -- and another thing that Cara had asked us  
10 to do was to look at gaps in research. So for the  
11 approaches that you all have identified where we  
12 haven't been able to find evidence for or few  
13 evidence for, it does set up a good case for us to  
14 say we need more investments in research in this  
15 area.

16 So, yeah, that does tie-in to mapping  
17 the domains and the interventions to measures.

18 But essentially what we wanted to do at  
19 this time was to just get your feedback on  
20 potential areas that we should be looking for  
21 measures beyond these usual measure repositories  
22 in the literature. And I know that you all have

1 actually mentioned a couple measures' resources  
2 throughout the meeting, but if you have any ideas  
3 it would be great to get your feedback.

4 That was a threshold for the gap, so  
5 the amount of disparity between the reference  
6 group and then the population with social risk  
7 factor.

8 DR. BURSTIN: It was actually an  
9 empiric decision as to whether it was a logical  
10 break in what we could find. But, again, all  
11 these are open questions. So if we want to move  
12 this forward, we would love your guidance on sort  
13 of really building it into something we could use.

14 And I love the idea of rather than  
15 mapping it to one of our practices, many of which  
16 I think will still be applicable, thinking about  
17 how it maps to the domains is just such a logical  
18 way to frame this going forward.

19 CO-CHAIR PONCE: Ignatius.

20 MR. BAU: So back to the comments about  
21 not generating a whole new set of measures that  
22 may not be aligned to what might be going on. I

1 think at some point it may be a futile exercise,  
2 but to map it to MIPS and to vital signs and this  
3 new Core Measures Collaborative that AHIP and CMS  
4 have come up with. And, again, it may map so that  
5 there are no measures that this committee focuses  
6 are that are in any of those sets. But even that,  
7 I think, would be an important communication to  
8 say we're completely outside the domain of where  
9 everybody else is.

10 DR. BURSTIN: That gets back to Bob's  
11 earlier point of could you pick the really high  
12 profile measures that are repeatedly used across  
13 the board. And maybe our explanation of this is  
14 even examining a very high profile set of measures  
15 repeatedly used across federal programs, how does  
16 this play out?

17 MEMBER RAUNER: That's why I asked  
18 about the 14 percent is because if you use blood  
19 pressure control and there's a 14 percent absolute  
20 difference between this group and this group, that  
21 could be a huge difference in mortality cost  
22 complications. So that's why I was asking why 14.



1 CO-CHAIR PONCE: Thank you. Nancy and  
2 then Romano.

3 MEMBER GARRETT: I'm just struggling a  
4 little bit with looking at the domains we came up  
5 with and then looking at these criteria. And I'm  
6 just not sure that they fit. So is the idea that  
7 this disparity-sensitive criteria would only apply  
8 to existing types of performance measures and not  
9 the new stuff we came up with?

10 DR. ANDERSON: Right. So that's why I  
11 said that we will have to retool this a bit for it  
12 to be more applicable. We are going to be looking  
13 at all measures that map to the domains that the  
14 committee identified. But we will also be looking  
15 more broadly at these more disparity-sensitive  
16 ones as well, just to -- it's kind of we wanted to  
17 just kind of put this out here as a tool that we  
18 can use to think a little bit more broadly.

19 CO-CHAIR PONCE: Romana. Oh, I'm  
20 sorry.

21 CO-CHAIR CHIN: Yes. In some ways it  
22 starts with the issue of prioritization. The work

1 on that prior committee, the Disparities  
2 Committee, was kind of a mixed bag in terms of  
3 like you got some interesting ideas out there, but  
4 ultimately I think was limited and unsatisfying.

5 But I think beyond what we talked about  
6 over the past couple days are some of these issues  
7 of like population impact. Because prevalence of  
8 the condition, the relative morbidity, is there  
9 something you can do about the item at all. So  
10 things that I think some of the complementary to  
11 the domains we talked about, but the domain part  
12 would need to be, probably an important part of  
13 it that was just questioned a little bit in the  
14 third box here on this old committee diagram.

15 CO-CHAIR PONCE: Romana then Sarah.

16 MEMBER HASNAIN-WYNIA: So this is just,  
17 again, since we're, Helen, I think you said that  
18 we can think about retooling this. So I'm looking  
19 at the disparities quality gap, and I understand  
20 that was the threshold, but I'm looking at the  
21 word gap. And I'm going to come back to  
22 improvement versus gap.

1                   So, for example, if we think about  
2 individuals with sickle cell disease, it's going  
3 to be really difficult to measure gaps; right?  
4 But we know that there are equity issues. And we  
5 know there are equity issues around pain control  
6 and a number of other metrics.

7                   So if there's a way that we can  
8 capture, maybe within the context of equity, I'm  
9 not quite sure how to get there. But I think you  
10 get my point.

11                  And there was something that Sarah said  
12 earlier -- I can't remember what it was -- but it  
13 also triggered, it was something about the within-  
14 plan disparities. So if we think about  
15 improvement, another way we can think about  
16 improvement is not just, you know, rising tides,  
17 but also if we look at national metrics, quality  
18 metrics where we expect a certain level of high  
19 quality and we see that there are disparities  
20 across different groups, that may, that may be the  
21 gap that we're trying to close if we're, you know,  
22 staying within the gap, the disparities gap

1 framework.

2 But my proposal is to include both kind  
3 of an equity metric as well as a disparities gap.

4 CO-CHAIR PONCE: Thanks, Romana.  
5 Sarah.

6 MEMBER SCHOLLE: Drew, for this work  
7 are you focused on the conditions that CMS  
8 specified?

9 DR. ANDERSON: Yes. Yes. So, we are  
10 using the conditions to bring up the example  
11 measures that fall within the domain areas. And  
12 I should have said that the measures are -- I  
13 guess what I'm trying to say, they're more it's  
14 going to be a very, like, illustrative example.  
15 Because there are so many measures, this is a way  
16 for us to prioritize the number of measures that  
17 would come up in these areas.

18 So the conditions will allow us to do  
19 some of that prioritization too.

20 MS. O'ROURKE: We were also thinking,  
21 particularly in the domain around quality, the  
22 selected conditions could be important case

1 studies where there will be a lot of the  
2 traditional structure process outcome measures  
3 that we might want to apply these criteria and  
4 determine which are the most equity sensitive  
5 within those conditions, given that the universe  
6 is large once you go into the quality domain.

7 But I think we want to go a little bit  
8 broader throughout the other domains and see what  
9 cross-cutting equity measures could exist.

10 MEMBER SCHOLLE: So did CMS share with  
11 you the environmental scan that NCQA did maybe  
12 over a year ago? Have you seen that?

13 I will mention to --

14 MS. O'ROURKE: Yeah, that would be --  
15 if that could be shared, that would be wonderful.

16 MEMBER SCHOLLE: Right. Because I  
17 think when you look at things that there's a -- I  
18 see how these are different, but I think that  
19 might be helpful to you.

20 And in some domains they're not  
21 condition-specific so, for example, patient  
22 experience, is that's not a condition-specific

1 topic area but it may be an area of particular  
2 interest, particularly around cultural competence  
3 or literacy or there are questions about mobility  
4 that would get at some of those issues, again,  
5 that are less about a disparity and more about an  
6 equity issue.

7 So it might be helpful to pull that in.  
8 I don't think the world's changed that much since  
9 we did it about 18 months ago.

10 DR. BURSTIN: And the prior time we did  
11 this it was not limited to a set of conditions.  
12 It was really a way to look across the entire  
13 portfolio and say which measures were particularly  
14 disparity sensitive and should always be  
15 stratified.

16 But it is interesting now, looking  
17 through the lens of conditions picked specifically  
18 because they have disparities. We'll have to  
19 think through how useful that might be.

20 DR. ANDERSON: Yes, but that's a very  
21 good point. We'll definitely look more broadly at  
22 those measures that kind of cut across conditions,

1 too, that apply to the domains.

2 CO-CHAIR PONCE: Any comments from  
3 those joining us on the phone?

4 CO-CHAIR CHIN: So I'm wondering, like,  
5 it looks like we have a little bit of extra time.  
6 And Susannah had a suggestion I think a little bit  
7 earlier about, a great one, if we have a few  
8 minutes to brainstorm, her point being that people  
9 made a number of really good comments that don't  
10 necessarily fit into the exact topic of today's  
11 meeting about domain selection and whatnot, but  
12 are going to be relevant, particularly for the end  
13 goal in terms of the recommendation report and  
14 all.

15 An example given like Romana's, where  
16 she just went on again in terms of closing the gap  
17 versus raising the absolute level type of thing.  
18 If we have a few minutes, if people can think  
19 about, like, over the course of a couple days, or  
20 their own comments, are there any things that you  
21 would want us to put in the parking lot so the  
22 staff can record it now so we don't lose it so

1 that we can come back to it as we go into a report  
2 for it eventually.

3 So a few minutes maybe for people to  
4 start thinking about that.

5 If you're still on the call, Susannah,  
6 you mentioned you had three that you were going to  
7 share. So if you are on the call, what were your  
8 three?

9 MEMBER BERNHEIM: Yeah, I am. I'm  
10 pulling them up. I'll see if they still seem  
11 relevant.

12 So the one thing that I heard people  
13 say a lot that I think is worth just naming is  
14 that addressing the impact of social risk factors  
15 may take extra resources. It's embedded in some  
16 of our domains but I think it's an important  
17 concept that keeps coming up.

18 One is that the way I was framing  
19 Romana's point was that, you know, it's most  
20 important to include overall care quality and  
21 outcome. That you can't just prioritize improving  
22 disparities without an examination of performance



1 and outcomes for the vulnerable population. For  
2 populations with social factors that influence  
3 health.

4 And then the third one was that both  
5 within and between disparities, both within and  
6 between institutions for regions or systems, are  
7 both important to examine and incentivize  
8 reduction. Those are the principles that I  
9 thought I had heard a lot over the last couple  
10 days that were worth kind of calling out in our  
11 report.

12 CO-CHAIR PONCE: So, Susannah, I heard  
13 two, not three. And the first was that you agreed  
14 with Romana about looking at overall improvement.

15 And the third was focusing on within  
16 and between disparities.

17 And I think I missed --

18 MEMBER BERNHEIM: Oh, the first one  
19 actually just this concept that I think it's worth  
20 us ceding that addressing disparities will take  
21 additional resources.

22 CO-CHAIR PONCE: Addressing disparities

1 will take more resources Marshall said.

2 CO-CHAIR CHIN: Yes.

3 CO-CHAIR PONCE: Okay.

4 CO-CHAIR CHIN: So thanks for starting,  
5 Susannah.

6 Do others have things they want to add  
7 based upon either their own thoughts or things  
8 people have heard over the past couple days?  
9 Sarah, no?

10 Nancy.

11 MEMBER GARRETT: You had just been  
12 saying a little bit ago, Marshall, about risk  
13 adjustment as one tool to try and level the  
14 playing field in that sense and make sure we're  
15 getting the resources the right places to reduce  
16 disparities and improve health equity. There are  
17 lots of others.

18 And so I really hope our committee  
19 speaks to those others and gets practical about  
20 what sorts of things can we do to start making  
21 those happen, even though it's kind of beyond the  
22 scope of what a normal NQF committee gets to do,

1 so.

2 CO-CHAIR CHIN: But, again, this is  
3 what's special to our committee, it's not beyond  
4 the scope. It's the first time that any of the  
5 equity committees have been told go for it. So  
6 we're going for it.

7 CO-CHAIR PONCE: Sarah.

8 MEMBER SCHOLLE: So we've talked a  
9 little bit about the audience that we're speaking  
10 to. And we tend to frame it in what does CMS want  
11 and what can CMS do? But there are other  
12 audiences that we might want to be considerate of  
13 and think about what that means, particularly  
14 states, given their greater primacy in this new  
15 world.

16 But, also, I'm particularly interested  
17 in thinking about how to address individuals, and  
18 for many of these publicly reported measures what,  
19 what we're communicating. And that may be  
20 something where we want to highlight how our work  
21 is relevant to those different stakeholders or how  
22 it's not.

1 CO-CHAIR PONCE: Thanks, Sarah.

2 Eduardo.

3 MEMBER SANCHEZ: I don't know if this  
4 is the right place or the right thing, but the  
5 presentation that came I think right after lunch  
6 was about, or maybe just lunch, was about the  
7 measures that exist and the degree to which  
8 they're being used. And Sarah did a presentation  
9 that also elucidated that, let us know that  
10 they're not being used.

11 But I talked to Sarah. And it sounded  
12 to me like the CMS data around race/ethnicity are  
13 not required, they're voluntary measures. And I  
14 just wonder if our recommendations, if we hadn't  
15 already thought about it, should include some  
16 statements about maybe moving from voluntary to  
17 not so voluntary. And what might be some other,  
18 some other bits of data that can and should be  
19 collected?

20 Because when I think about the  
21 opportunity -- and, again, in the conversation  
22 with Sarah we're talking Medicare as potentially

1 a place where we could gather data; Medicaid; the  
2 degree to which exchanges continue, that's another  
3 place. And that can begin to set the stage for  
4 what others would and should be capturing because  
5 the degree to which it's Medicaid managed care  
6 plans that are done by the private and/or Medicare  
7 Advantage, that you again begin creating at least  
8 enough of a intervention into the way people do  
9 their business that they may just decide we ought  
10 to be doing this for all of our business.

11 That was one.

12 The second, and I wonder if there's an  
13 opportunity for us to include in there a  
14 recommendation for CMS to nudge, if that's the  
15 right political term or bureaucratic term, to  
16 nudge IRS to perhaps put a bit more teeth into  
17 what data is collected at a CHNA level so that we  
18 have a different way of getting at the community  
19 level data in addition to patient-specific  
20 gathered data.

21 CO-CHAIR PONCE: Great. Thank you.

22 The Medicare data looked like it was

1 doing better than commercial based on the --

2 MEMBER SANCHEZ: Yes.

3 CO-CHAIR PONCE: But the commercial was  
4 still, or race was still 70 percent unpopulated,  
5 but it was missing or not, which is I think the  
6 case from 10 years ago when we were on the  
7 committee, looked at data quality.

8 Nancy.

9 MEMBER GARRETT: Well, I also wonder,  
10 based on some of the discussion about our data  
11 scarcity about if there's a different way we can  
12 engage the private sector. So we talked about  
13 companies like Acxiom and, you know, some of the  
14 users we've had. And we had kind of a sidebar  
15 conversation over the break about credit card  
16 companies and companies like Experian that almost  
17 all providers work with. Some companies like that  
18 in their revenue cycle processes to try and  
19 understand risk, financial risk and target  
20 resources. And that's a great proxy for the kind  
21 of SES variables we're trying to get at.

22 And they're not really represented in

1 our group. And I just wonder if reaching out to  
2 them in a more systematic way would be helpful in  
3 these conversations.

4 CO-CHAIR PONCE: Great. Thank you.

5 Just a clarification to Christie.

6 Isn't the Acxiom data, doesn't that include some  
7 of the financial data, and Experian?

8 MEMBER TEIGLAND: Yeah, it totally  
9 does. They have a whole module on financial  
10 aspects of what would an Experian collect to get  
11 your credit score. So do you pay your bills on  
12 time? You know, what are your financial buying  
13 habits and payment habits and so forth? Do you  
14 have credit cards? I mean there's a whole set on  
15 that in the Acxiom data, actually, as well as an  
16 income section, you know, social, you know, buying  
17 behaviors. There are many, many sections in that  
18 data.

19 MEMBER GARRETT: But one difference  
20 might be that a lot of providers are already  
21 working with the -- it's the revenue cycle --

22 CO-CHAIR PONCE: Right.

1                   MEMBER GARRETT:  -- the credit  
2                   companies in the process, and so the data already  
3                   exists in a sense out there.  And so it just might  
4                   be a different relationship to explore.

5                   CO-CHAIR PONCE:  Yes.  Noted.  Thank  
6                   you.

7                   Kevin.

8                   MEMBER FISCELLA:  Yes.  I agree with  
9                   your earlier comments.  I do think regarding the  
10                  whole issue of risk adjustment here and where to  
11                  go, I do worry that until there is some sort of  
12                  adjustment that there will be continued both angst  
13                  on the part of hospitals and safety net providers  
14                  that, one, they would be gamed and, two, I think  
15                  it undermines the credibility of the measures.

16                  Despite the empiric evidence I think  
17                  there's a perception -- and it may not hold for  
18                  all the measures, and there may be some, like you  
19                  said, if you're 200, one that's way out of whack  
20                  that you really could end up paying a whole lot of  
21                  money.

22                  And if by and large the variances is



1 relatively small, it probably is, the risk of sort  
2 of lowering the bar is probably relatively low.  
3 In other words, it plays on both sides. If you  
4 see big effects then, you know, in fact if you're  
5 worried that you may be in essence lowering the  
6 standards of care with that adjustment, that's a  
7 much bigger concern than if the effects are  
8 relatively modest.

9 But at the same time, I think we can't  
10 deal with that issue without the issue of active  
11 interventions to begin closing that gap and  
12 finding ways through innovative payments to begin,  
13 you know, perhaps going after some of these  
14 quality gaps directly. That would then begin to  
15 address those gaps and promote from our equity.

16 So I think that the conversation around  
17 ultimately where do we go with SES risk adjustment  
18 I think needs to be linked to, well, what else are  
19 you going to do on the other side to promote  
20 equity. Because, clearly, just adjusting for SES  
21 is not going to be a panacea in terms of resources  
22 for safety net hospitals. I think that's pretty

1 clear and that's not going to happen.

2 Failing to do it, probably on the  
3 average, on the net average is going to hurt some,  
4 and probably some quite a bit. But if we really  
5 want to get resources to these hospitals in a way  
6 that incentivizes equity, then we need to do that  
7 in more direct ways. And I think that that's  
8 probably our next task, to really be brainstorming  
9 about that and thinking more deeply about how to  
10 do that.

11 CO-CHAIR PONCE: Thanks, Kevin.

12 Helen.

13 DR. BURSTIN: I'm just going to follow  
14 up on something Kevin said, another issue I want  
15 to make sure we don't lose sight of. So even if  
16 we think beyond adjustment and think about  
17 payment, there are different ways even around the  
18 measurement side I don't want to lose sight of.  
19 So, awhile back we talked about, for example,  
20 rather than paying not achieving a threshold, you  
21 pay for degree of improvement. You know, there  
22 are some strategies around measurement and payment

1       that could still work best to close gaps and  
2       improve equity beyond the adjustment fees.

3               CO-CHAIR CHIN:   Right.   And we might  
4       look, it's one of the NAM reports, I think it may  
5       have been Report 3 or 4.   There was a nice chapter  
6       around 8 or so that has like eight different ways  
7       of variations on, like, ways to pay.   It goes  
8       through a nice schematic.   It might be well to  
9       pull up this.

10              DR. BURSTIN:   Yes.

11              CO-CHAIR PONCE:   Philip.

12              MEMBER ALBERTI:   Just also picking up  
13       on Kevin's point in terms of measurement to  
14       action.   Right?   So, we spend a lot of time  
15       thinking about not only internal structures and  
16       culture for equity, but also the kinds of  
17       partnerships in data collections and  
18       collaborations that are really necessary for  
19       safety nets in all hospitals to really do this  
20       work.

21              Part of me thinks -- and I don't know  
22       what this would look like or how we would

1 operationalize it here -- that we should walk that  
2 walk as a committee and begin to think about the  
3 development of metrics in partnership with housing  
4 and transportation, education; right? Some of the  
5 solutions live there. We're going to suggest that  
6 institutions and communities and patients and  
7 families be measured in some way in these  
8 intersectional kind of ways that we should think  
9 that through with our partners that also have skin  
10 in this game.

11 CO-CHAIR PONCE: Thank you. Eduardo.

12 MEMBER SANCHEZ: I'm going to piggyback  
13 on that because a thought that I had a moment ago  
14 is, and I don't recall from the second report the  
15 degree to which, in the spirit of what Philip  
16 said, we've thought about the criminal justice  
17 system as the place where most mental illness care  
18 happens for most people in most states. And then  
19 the degree to which the work we do is going to  
20 capture that, capture the disparities. And think  
21 about both from a direct clinical intervention  
22 perspective on the one hand. And then policy

1 solutions that are outside of the clinical realm,  
2 quite frankly, on the other hand we might think  
3 about that.

4 And that's gargantuan. And I don't  
5 think it's quite the same in any of the other  
6 realms. But in mental illness it is, it's, it's  
7 huge.

8 CO-CHAIR PONCE: Thank you. Kevin.

9 MEMBER FISCELLA: Yeah. Just a  
10 piggyback on Eduardo's comment on the criminal  
11 justice system. I think that may be an area where  
12 we could think about some equity measures,  
13 particularly in terms of exchange of information  
14 and in-reach for pre-release care coordination.  
15 I think is really, you know, probably if you're  
16 going to look at what's going to have the biggest  
17 bang for the buck in terms of improving the  
18 healthcare or health of jail and prison inmates,  
19 it's at that period before their, before their  
20 release.

21 In fact, New York State had a waiver --  
22 I think it's been temporarily withdrawn -- for its

1 DSRIP program, amendment to the waiver, to have  
2 Medicaid, to allow Medicaid to cover the cost of  
3 that, of that in-reach that would provide for  
4 consultation as well as, you know, medications.  
5 So that then when the inmate was released they had  
6 an adequate supply of medication, not just, you  
7 know, a 5-day supply with the, you know, hope that  
8 they're somehow going to magically connect with a  
9 provider within that time.

10 So I think that thinking about how  
11 health plans, ACOs, measures there that might look  
12 at that pre-release care coordination between  
13 jails and prisons and the community could in fact  
14 be a type of equity-sensitive measure.

15 CO-CHAIR PONCE: Thanks, Kevin.  
16 Christie.

17 MEMBER TEIGLAND: Yeah, just one, one  
18 more quick comment on the medication adherence  
19 measures.

20 I mean one of the most predictive  
21 factors is alcohol, drug/substance abuse, and then  
22 mental health conditions like schizophrenia, major

1 depression, bipolar. Those folks are much less  
2 likely to be adhering to their medications.  
3 They're very not adherent to their anti-psychotic  
4 medications, which then leads them not to be  
5 adherent to their diabetes and cholesterol  
6 medications.

7 Those measures aren't adjusted for  
8 those factors because they want them to be, you  
9 know, applicable across all types of plans. And  
10 so because there are Medicare Advantage plans that  
11 provide drug benefits, but then there are Medicare  
12 Advantage plans that just are Part D, drug benefit  
13 plan, they don't use any of the clinical factors  
14 to adjust those measures because they it wouldn't  
15 be fair, right, it wouldn't be a fair, you know,  
16 level playing field across the types of plans that  
17 provide the same services to the beneficiaries.

18 So, you know, that's another issue to  
19 think about is applicability of some of these  
20 adjustments, even though they're very appropriate.  
21 There's certainly a conceptual and empirical  
22 basis, but it's not practical in practice. And

1 so, you know, I know they're trying to synchronize  
2 measures across all these levels and of payer  
3 types and systems and all the levels we talked  
4 about. Sometimes that's not easy to do. Right?

5 CO-CHAIR PONCE: Thank you. Nancy.

6 MEMBER GARRETT: And Christie's comment  
7 just reminded me that this, we did talk a little  
8 bit about data sharing and policy and legal  
9 barriers to that. And I just wonder if somebody  
10 on our committee might want to have a parking lot  
11 item, is there anything that we can do to make  
12 recommendations in that space?

13 And I'm thinking about data exchange  
14 between medical care providers and social  
15 services, as well as substance abuse, data  
16 sharing. You know, there's a lot of legal  
17 restrictions there that are a big barrier. I know  
18 people are working on that but can our committee  
19 do anything that will make recommendations?

20 CO-CHAIR PONCE: Thank you.

21 On the phone, Dave, any parking lot  
22 suggestions for us?



1 (No response.)

2 CO-CHAIR PONCE: Okay. And Susannah  
3 and Yolanda?

4 MEMBER BERNHEIM: No. I would just  
5 reflect that I heard a mix of things that might  
6 fall into the parking lot suggestions and of  
7 things that might fall under the category for  
8 principles or concepts that we thought were  
9 important to highlight in the report that we may  
10 want --

11 CO-CHAIR PONCE: Yes.

12 MEMBER BERNHEIM: -- to separate.

13 CO-CHAIR PONCE: Yeah, good point.

14 CO-CHAIR CHIN: I'm going to call  
15 Ignatius. He's been quiet, very quiet. And he's  
16 a font of knowledge.

17 CO-CHAIR PONCE: We'd like to open for  
18 public comment for those on the line, please.

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

22 Okay, we do have a public comment from

1 Jayne Chambers.

2 CO-CHAIR PONCE: Thank you. Go ahead,  
3 Jayne.

4 OPERATOR: Jayne, your line is open.  
5 If you've muted, please unmute.

6 MS. CHAMBERS: Hi. This is Jayne  
7 Chambers with the Federation of American  
8 Hospitals. I really appreciate the robust  
9 discussion that you've had this afternoon. I  
10 wasn't able to listen to yesterday's, but I was  
11 able to listen today. And I appreciate the  
12 thoughtfulness with which you are approaching  
13 these very difficult subjects.

14 I did think that the committee should  
15 be aware that the hospital community has written  
16 a letter to NQF that I think will be shared with  
17 you at some point soon that asks for an extension  
18 of the trial period, for the SES trial period. We  
19 think that it's important for us to clarify what  
20 the trial period was trying to do. We think that  
21 there may not have always been clear communication  
22 and the community may not necessarily have

1 understood what they should be trying to do in  
2 terms of testing various models and bringing  
3 forward some ideas and proposals to consider how  
4 to go forward and in what cases you might want to  
5 test measures and how we should test them.

6 So just wanted the committee to be  
7 aware of that. And I look forward to continued  
8 discussions.

9 Thank you.

10 CO-CHAIR PONCE: Thanks, Jayne. And it  
11 just has been dispatched to us. Thank you.

12 MS. CHAMBERS: Thank you.

13 OPERATOR: Okay. At this time there  
14 are no public comments.

15 CO-CHAIR PONCE: Thank you. Any  
16 comments from those joining us?

17 (No response.)

18 CO-CHAIR PONCE: Okay. We'll turn it  
19 back to Erin.

20 MS. O'ROURKE: Great. Thank you so  
21 much.

22 So I'm actually going to turn it right

1 to Mauricio so he can cover the next steps and  
2 what to expect in the coming weeks.

3 MR. MENENDEZ: Hi, everyone. I won't  
4 keep you here any longer than we have to be.

5 So the PowerPoints and the materials  
6 from the meetings are available now on the  
7 committee's share point. We'll also be following  
8 up with the homework assignments that we talked  
9 about earlier, as well as a more built operation  
10 of the roadmap.

11 Next slide, please.

12 For the third -- yeah, the slide before  
13 that. Yes.

14 For the third disparities report it  
15 will include the scan for performance measures.  
16 And we'll also be searching for current or  
17 emerging evidence-based practices with respect to  
18 measurement of effective interventions to reduce  
19 -- with respect to measurement of effective  
20 interventions to reduce disparities.

21 We'll also include an updated  
22 conceptual framework, along with a the revised

1       amazing concepts that the committee came up with.

2               Next slide, please.

3               And the final report, it will be a  
4       composite of the previous three reports. It will  
5       also include the committee's recommendations. And  
6       along with that we'll have the 30-day public  
7       comment period, along with the final report.

8               And turn it back over to Erin. Thanks.

9               MS. O'ROURKE: Okay. So just to maybe  
10      pull some of those pieces together. So the third  
11      report we'll be, again, working with you virtually  
12      to get your input before our June meeting. I  
13      believe that's due May 15th. Drew, correct me if  
14      I'm wrong.

15              DR. ANDERSON: Yes.

16              MS. O'ROURKE: Yes. Okay, so we will  
17      do some more virtual work. Perhaps we won't use  
18      Google Docs, given that no one likes it. And I  
19      had a feeling your team --

20              CO-CHAIR PONCE: No one likes it over  
21      30.

22              (Laughter.)

1 MS. O'ROURKE: So we'll find maybe a  
2 better way to collaborate and get virtual input  
3 that is a little less frustrating.

4 We'll bring the findings of that report  
5 to you at the June meeting, in particular what we  
6 found for the environmental scans from measures,  
7 so that the committee can start to do some of the  
8 work to prioritize and help us identify the best  
9 possible set for measures.

10 We'll also spend quite a bit of time  
11 on, as Mauricio was saying, the policy levels and  
12 what we can do to get these measures in use, how  
13 we can really not just put together a set of  
14 measures and gaps but really put some teeth behind  
15 them and what other things we could do.

16 And then the third map we'll really be  
17 pulling those three threads together from the  
18 first, second and third report so that, hopefully,  
19 the whole picture of what the roadmap is and where  
20 we can go is clearer. So that one will come out  
21 after your second in-person meeting. It will  
22 include the findings of that, that meeting. And

1 then we will bring you back together virtually, I  
2 believe in August, to review all the public  
3 comments and make any applicable updates. So.

4 CO-CHAIR CHIN: Question for Helen. Is  
5 there any idea about the communications plan for  
6 the final report yet?

7 DR. BURSTIN: No. Have some things to  
8 talk about with CMS.

9 MS. O'ROURKE: Yes.

10 I think with that -- Eduardo?

11 MEMBER SANCHEZ: Along those same  
12 lines, is there -- and maybe I missed it -- is  
13 there a formal, is there a plan for formally  
14 engaging and inviting input of other  
15 organizations? I think the American Heart  
16 Association would appreciate formally providing  
17 public comment. And there may be others.

18 I'm speaking out of ignorance.

19 MS. O'ROURKE: Oh. Actually, so just  
20 to -- we would love if all of you could share the  
21 draft report for comment with your organizations.  
22 And we do have a process to receive formal

1        comments from outside organizations and respond to  
2        them. So I think if there's anyone in your  
3        network that would have insight who would like to  
4        share comments, we'd welcome that.

5                    CO-CHAIR CHIN: And it dovetails with  
6        Philip's point about partisan collaborations, and  
7        so that if there is sort of a projected arc of  
8        this, then it may make sense strategically think  
9        about how to embed it at this stage, yes.

10                   MEMBER SANCHEZ: So, and again just not  
11        to beat this to death, but as an example, in a  
12        couple of weeks the National Hispanic Medical  
13        Association is doing something. And I just wonder  
14        if around this particular document there aren't  
15        some organizations we want to make sure we put it  
16        in front of them and ask whether that's NMA or the  
17        Association of Black Cardiologists. There's many,  
18        many organizations out there. But they may have  
19        -- And then that's the provider organizations.

20                   You've got hospital associations and  
21        others that may have not only a vested interest  
22        but really be keen on knowing this is happening



1 and might provide some insight and appreciate the  
2 opportunity to have been asked. And, again, I  
3 figure you have that thought out. But I see other  
4 organizations that sometimes think they have that  
5 thought out, and two months later you hear that  
6 the report came out and there was public comment,  
7 and you know your organization was in no way  
8 informed.

9 MS. O'ROURKE: I think that's an  
10 interesting idea. Helen, I'm looking at you.

11 So I think we do have our formal public  
12 comment process. But perhaps we could brainstorm  
13 with you all over email who we can engage earlier  
14 and what groups want to be invited to the public  
15 comment. What we can do a little more upstream so  
16 that --

17 DR. BURSTIN: We've done that before.  
18 For example, we have a report that's out, just  
19 finished comment on diagnostics safety and  
20 quality. And used the Society to Improve  
21 Diagnosis in Medicine's 35 percent collaborative  
22 to say send this out on your listservs. And we've

1 had a lot of comments. So, not surprising.

2 So any input from you on which places  
3 to post it for comment would be all in.

4 CO-CHAIR CHIN: Yes. And if we just  
5 don't want it to be a report on a shelf, this is  
6 the way to do it.

7 CO-CHAIR PONCE: And I'm wondering, I  
8 don't know how many people were on the public, you  
9 know, section online, but for the SDS and risk  
10 adjustment there seemed to be a really hefty of  
11 both consumer, provider groups.

12 DR. BURSTIN: Highest number ever. 650  
13 comments on a single report. Still holds the  
14 record.

15 CO-CHAIR PONCE: Yeah. Well, I'm  
16 wondering if that's because the public doesn't  
17 know what our policy influence is? Or, you know.

18 DR. BURSTIN: It's highly variable, at  
19 least in my decade here. It's about how important  
20 the report is in the eye of various stakeholders.  
21 Is it sexy? Is it important? Is it timely.

22 And, secondly, I think it's how good a

1 job you do to let people know.

2 CO-CHAIR PONCE: Okay.

3 DR. BURSTIN: And, you know, with your  
4 help we could certainly fix the second one. I  
5 think the topic is obviously going to be,  
6 particularly with all the Medicaid discussions  
7 swirling around.

8 MEMBER SANCHEZ: I think that in the  
9 space of value-based health this is really, really  
10 important. Thank you, Erin.

11 MS. O'ROURKE: So, I think just on, so  
12 not perhaps immediate next steps, but we'll be  
13 coming back together June 14th and 15th. Similar  
14 process for travel as this time. You'll get a  
15 memo about a month in advance saying our  
16 department will let you know how to book  
17 everything.

18 I think, Drew, Tara, did I miss  
19 anything logistically?

20 DR. ANDERSON: Different hotel.

21 MS. O'ROURKE: Different hotel. Yes,  
22 apologies that that was a less-than-ideal

1 situation.

2 But, yes, thank you so much all for  
3 coming and for all your wisdom and insight over  
4 the past two days. This has been phenomenal.  
5 We've got a lot to take back and to start to map  
6 out the roadmap to bring you something, hopefully,  
7 more concrete in June so that we can get that  
8 finalized and get it out to the world to Eduardo's  
9 point to hopefully give it some legs.

10 A special thank you to Marshall and  
11 Ninez for your moderating the past two days and  
12 for how much of your time you volunteered outside  
13 of the formal meeting to help us plan and get  
14 everything together. We really appreciate it.

15 CO-CHAIR CHIN: And I want to extend my  
16 thanks to the committee and to the staff, and  
17 Ninez and Helen and everyone here, that I think  
18 this is maybe my 15th to 20th NQF meeting. And  
19 this, this may have been one -- this is one of the  
20 top three anyway. One of the best ones. I mean  
21 just the input of everyone.

22 And, you know, talking about that on

1 the breaks, but we had no idea where this was  
2 going to go. But I think the discussion was  
3 great. And it really brought out the whole span  
4 of things. And people are really big thinkers and  
5 no one was narrow. So it was just great.

6 So thank you very much.

7 CO-CHAIR PONCE: Thanks. Safe travel.

8 MS. O'ROURKE: Yes. Thanks everyone.

9 Safe travels and we'll see you in June. But  
10 you'll probably be hearing from Tara numerous  
11 times in the interim with homework.

12 (Whereupon, at 2:35 p.m., the meeting  
13 in the above-entitled matter was adjourned.)  
14  
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