NATIONAL QUALITY FORUM

\+ + + + +

DISPARITIES STANDING COMMITTEE

\+ + + + +

TUESDAY
MARCH 28, 2017

\+ + + + +

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
for Quality Assurance
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

CONTENTS

Recap of Day 1 and Goals for Day 2

Data Considerations

Hospital and Community-Level Factors Discussion

SDS Trial Evaluation

Environmental Scan

Next Steps

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

9:14 a.m.

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

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

We also printed the longer list of domains and sub-domains that we ended on yesterday, so you can compare the two of them. And so today what we wanted to do was walk through the revised list that staff came up with yesterday and kind of crosswalk between the two and then talk about them section by section just to see what needs to be revised or moved around or added or removed.

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

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

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

CO-CHAIR PONCE: I just wanted to thank everyone. I thought that this was a really challenging day to plan, and it could, as I told some other people, it could have spun out of control. But I think it was done in a very thoughtful way and where we were able to expand the thinking but then bring it back in. And I think I want to thank the staff at NQF for helping with that.

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

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

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

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

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

And then we have the culture of equity, and this is where we put all the ideas of cultural competence that's reached through all the levels that we discussed and the focused areas that we discussed yesterday. We specifically called out bias and measuring bias and stigma, which was something that came up yesterday, as well. And we put in this idea of prioritizing equity and decision-making, which is more of the higher-level aspects of using data about disparities and reducing disparities to drive decisions.

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

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

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

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

CO-CHAIR PONCE: Eduardo?

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

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

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

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

--

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

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

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

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

I just feel like we would need to change the words a little bit. Like the categories are probably okay, but the material context in which care is delivered, that really sounds like you're talking about a provider organization. But you could imagine structural things at a policy level, for example, income and equality is a basic reason why it's hard to deliver equitable care, the way reimbursement works, kind of the bigger structural issues around what social services are available in different areas to help address social determinants.

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

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

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

But from our very first meeting, I know the majority of the group wants, it's much broader, talk about the social ecological model, talk about social determinants and interventions at levels far beyond the provider organization. So I was actually a little surprised to see what I thought was a focus on the provider level, but I didn't think the group was going to go there. And, apparently, the group has not gone there, so that's okay.

CO-CHAIR PONCE: Okay, thank you. Kevin?

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

A couple of amendments. Under structure, I would make sure we have learning organization in there. And I would say learning organization, actually that was the original blanket on the guy who wrote the book on that. But another organization I think will encapsulate what we talked about yesterday, I think also under structure, that's under structure. And also under structure, I think a system for assessing what the needs of the patient population is. I think that there needs to be a systematic systems to really understand what those needs are and then, of course, a system aligned with adequate resources to address that. So that, I think, would go under structure.

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

Of course, psychological safety goes beyond race and ethnicity, but I think that that fundamental culture is needed. And I think an appreciation relating to that is an appreciation, which probably goes a little more beyond psychological safety, an appreciation for diversity in perspectives, particularly from people from historically marginalized or stigmatized groups because I think the culture is absolutely essential to moving forward.

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

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

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

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

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

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

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

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

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

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

MEMBER RAUNER: He's going to actually do a little more on Kevin's talk about the data or lack thereof, and then I think that needs to be sort of really called out. Underneath the data and identification is that we need data for equity that we don't have right now. Most of what's out there is impeding from the ZIP code level and things like that. It's not granular enough. It's collapsing to just white/non-white. We need better patient-level data that includes those demographic factors because I think that's one of our limited major limitations, and I think it should be kind of specifically called out that we need to build that data. Whether it stays under that major section or whether data for equity is moved under commitment to equity, we think we really need to specifically call out the data that's missing that prevents us from doing what we're really assessing well, things we need to assess.

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

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

CO-CHAIR CHIN: Microphone.

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

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

MEMBER IEZZONI: Okay. Because the electrical outlet here wasn't working. Okay. A couple of points. I think, Kevin, it's great to have psychological safety. When we've looked at safety in the disability community, they tend to focus on emotional safety and physical safety. And the word emotional is used especially by the community of people who are in mental health recovery because they are often kind of stigmatized, especially when they go into emergency departments or so on. And so I think that it is really important to extend beyond psychological to maybe emotional safety.

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

The data and identified patient social risk puts this communicative structure at a disadvantage that I kind of feel responsible for with helping with the language. I make data, which is kind of an obvious place for me to put it. And so I've been trying, because it doesn't really capture what I meant when I kind of raised the topic yesterday in our rogue group. I actually might put it under the culture of equity, kind of a mission that there are generations literally of people with social disadvantages or disadvantages of some sort that leads to kind of challenges in terms of regaining the help that the healthcare system intends to apply. And so I think it would be good to have a little bit more discussion about where that concept, where that belongs, because I don't think it belongs under data.

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

MEMBER IEZZONI: But maybe we could use slightly different words to kind of tease out those nuances so it's clear that one belongs in one place because they are different nuances.

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

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

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

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

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

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

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

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

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

MEMBER ALBERTI: So, first, this is great. I think it's really an amazing attempt to kind of organize all of our thoughts from yesterday. So I don't see this necessarily as like a one-to-one mapping exercise, right? I think the metrics that we end up developing could fit into two different domains you could address. So, you know, where things specifically go, I'm not sure that we have to figure out the right spots.

So just a couple of thoughts about this. So in terms of the partnerships and linkages, I think the cross-sector partnerships limits it. It puts it automatically at a higher level. So I think if we just have a broad domain of partnerships and linkages, that could be everything from those individual connections that we're talking about to the data connections we're talking about, the actual cross-sector partnerships in the community. I mean, I think it could be broader, and I think that's something like what Romana was just saying in terms of direct connection through HIT from social services to the hospital to kind of have that connectivity. That could be both under that domain of partnerships and linkages, as well as the structure for equity, because without the technological infrastructure to promote this work, it can't go forward.

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

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

And the last thing I'd say is that I think that the data and identification of social risk could absolutely be under the structure for equity. And I think that, in terms of parsimony, if you really want to lump into larger groups, that is such a sine qua non of the work, that if you don't measure and assess and routinely do that piece and report and hold folks accountable, I mean that is really like a cornerstone of the structure that we're talking about.

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

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

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

One of the reasons why it was separate

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

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

So I'm curious, given like tradeoffs here where the managing of the cross-sector parts, if you want to highlight that, versus being that it is more specific. So if you want it to have a more general flow, then your suggestion made a lot of sense. I'm curious to know, like, your thoughts or your group thoughts about, like, that type of choice of like, a choice which basically, it did highlight sort of the cross-sector social factor or Romana's point about sort of pushing to beyond what the healthcare system is right now versus a more general model.

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

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

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

I'm agnostic, I think, I'll open it up to everybody else, in terms of whether, you know, the collaboration and the data piece are so key that they need to be separated out even if they might logically fall under another domain. Whatever, politically, advocacy-wise, whatever is going to make the rubber hit the road with the most traction, I think that's what we should do.

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

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

Also, just reflecting on the point about data exchange. I think that we should be clear that, just as we have regional health information organizations that are developing and that can be measured, that those organizations should include social service, community-based organizations, that they should be brought into that HIE environment. And to the extent that it's something that's very measurable and that people are doing to different extent around the country.

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

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

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

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

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

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

I wanted to call out, I just want to make sure I understood the conversation about learning system on equity. I see right now it's under culture of equity. I've heard it maybe it should be under structure for equity. Is this the quality, you know, a quality dashboard? Is this a QI effort, incentives for equity? Is that where that fits? If it is, I think this language of learning system may be something that is not as clear as it could be for a broader audience because the more we can be clear and concrete about what we expect, the better. And maybe I'm not understanding all the theory behind the learning system, but some of this has to do with stratified reporting and public reporting, and so it could be for the learning system, but it could also be for more public engagement. And maybe you'd like for those things to go hand-in-hand, but maybe they wouldn't always do that.

The other comment I had is about digital, I mean what we have called telehealth. Here, in other work that we're doing, the term digital is a broader term that includes both the synchronous video conferencing along with all the other ways that you can interact with people using technology. So I would suggest that we consider changing to that term to be broader because there's many ways to reach out to people using electronic tools.

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

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

MEMBER FERGUSON: Yes, yes, I made the comment. And I think it's under the address bias, that if you don't really think about it, it's more in terms of how can we really see cultural competency at the provider level as to how they're actually interacting with different members, the different types of patients. So I think it's in terms of how we can see cultural competency in action.

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

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

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

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

Lisa?

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

Okay. Either a leaf or a branch under equitable access to high-quality care I think does need to be timing of services for services available at more hours of the day than just during regular business hour. I recently reviewed some literature that suggests for Medicaid populations that they're less likely to use emergency department services if their primary care providers actually have evening hours and weekend hours. And so I think that that would be a nice thing just to add there, and it's very measurable.

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

And I also wonder how you would factor in communications with people with intellectual and developmental disabilities, the fact that you might need to communicate in very different ways to be able to allow them to comprehend what you're talking about. For example, girls who are about to get their first Pap smear, oftentimes a provider might use dolls or something like that to show what happens during your Pap smear.

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

CO-CHAIR PONCE: Thank you, Lisa. Nancy?

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

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

And then the second comment is around, under equitable access, the segregation of services. I don't think that captures what we were talking about yesterday. I would call it segregation of patient populations across providers, and I would put that under structure for equity. Again, it's not a value judgment. I mean, there's good and bad about that segregation, but it's something that we need to understand because it determines how resources are distributed and it determines kind of how services are grouped and that kind of thing. But I think it's not just about access. It's a broader concept.

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

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

CO-CHAIR PONCE: Okay.

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

CO-CHAIR PONCE: Not have a date category.

MEMBER RAUNER: It should be part of

all categories.

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

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

MEMBER GARRETT: That's an idea.

CO-CHAIR PONCE: Okay. Ignatius?

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

So it's just another reference point.

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

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

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

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

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

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

MEMBER OGBOLU: Yes --

CO-CHAIR PONCE: -- capital.

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

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

And then I just wanted to say something about the cultural safety versus psychological safety comment that was just made. I think somebody mentioned it has been used in nursing, and we do use it. One of the interesting things when it comes to issues of equity and addressing bias is that this cultural safety is both at the patient level and the provider level. Providers often say they don't feel like they have a safe environment to be open and admit that they don't understand how to address some issues related to bias and also to providing culturally-competent care. So it's cultural safety for patients and also for providers.

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

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

MEMBER OGBOLU: Yes. In terms of the social cohesion, you could look at that as multi-level. I think somebody mentioned still looking at things from the policy level and the patient level. I think that's still important, as well, because when I think about social cohesion, it could be related to the community linkages in terms of cohesion between the healthcare organizations and the community, as well as on the individual level, the individual patient level, so I think it can mitigate, you know, social risk. So if you have better social cohesion, obviously, you know, it could be protected from some of the social risks.

So those were just the comments I had from listening.

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

So I think it was like the group in the corner, it was like Philip and Drew's group, where, if I recall it right, they were the white sheets that had the closest to that under one of their domains. I think it was like the equivalent of their commitment to equity domain, and they actually had a lot of that mapped out, like the data collection, then use in quality improvement, doing interventions, and implementing it all.

On one hand, you can try to sort of build it into like these kind of domains. I mean, some of the suggestions about like moving data under the commitment to equity and structure and look at the quality and etcetera. The other is that we have our overarching conceptual framework. Again, that one that has like the data circle, and then there's like actions, like payment and stuff, at the bottom. So there could be the linkage then of the domains mapped to the overarching model. Well, we could try doing both, but I do hear this message of like right now, unless like one of those is done, whether it's like within the domains themselves or us linking to a wider district of model, people are finding that it doesn't, it's not as valuable as people would want it to be, I guess, if the how-to isn't somewhere there within the domains or else linked to like our existing model.

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

And then when Romana was saying, like, how to, these community health system linkages as how to, so social capital and social cohesion in the WHO model are actually the mediators between these big structures, structural, and like governance, big policies, and cultural.

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

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

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

DR. BURSTIN: I could take a crack at it. Some other folks from CMS will be maybe listening in, as well. If any of them want to chime in, operator, please open their lines. I think we've been sort of waffling back and forth between this sort of micro-view of what's the here, the now, the actionable, and not wanting to lose the context. So I think it's fine to have the broad range, and I, actually, as we were speaking, could see sort of visually sort of a funnel of what this work looks like. Again, maybe it's not linear but it's actually sort of something that says we recognize some of this is at the broadest level, some of this begins to hone in to thinking about where community and clinical health system come together, this is where the clinical space could be. And I think you could logically think about measures that might be for accountability. Some measures might be the ones that would get health systems to start moving in this direction, but not necessarily something that CMS would pick up on.

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

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

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

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

So for example, an example of a media goal would be existing data-based purchasing programs. Well, why can't we build in some type of equity measures? I mean, that's what we've been talking about the past couple of days. Why not? And then some things that maybe longer term, though not that far off the horizon. So some of the population-based health rings, well, you can see why it's not a cure yet but shouldn't be that far away for a lot of the things we're talking about with social factors, for example, and the partnerships.

Things need to be done in a evidence-based way. So my sense is like why, like we've had these four two reports which I think a lot of it seem kind of distal. I mean, why do we need a document where we already know regarding disparities among these five different groups and all? Well, I think our answer would be that you need to have this evidence-based approach, so systematically you've got to describe the disparities, the second report where we've got systematically show what the evidence base is because the measures we're going, that we're developing, some will be evidence based and some are going to be aspirational of, well, measure developers need to develop that. But to be able to have a validated measure that can fly, well, it's got to be this evidence base. But the ultimate goal, I mean, a very practical goal of using the leverage that are available then to improve equity.

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

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

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

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

CO-CHAIR PONCE: Thank you. Susannah?

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

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

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

And then I agree with you, Helen, what we can start to do is build sub-domains, and we can indicate some of these are, we can find a way to sort of say, like, you know, there's a ton of evidence in this area that this is important for equity and there's less evidence in this area.

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

So I think, I don't think we have to be limited by the evidence piece. And, again, there's also a little bit of a difference between process and outcome measures, right? When we sit in front of NQF with an outcome measure, we have to show that there's some evidence that there's things that hospitals or clinicians can do to influence that outcome. But it's a little bit different than the process measures. The process measures are a little more constrained. There you have to sort of say, like, you know, we have five RCDs that show if you do this you get better outcomes.

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

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

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

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

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

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

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

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

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

CO-CHAIR PONCE: Okay, thank you. Traci?

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

So I would think in terms of what we're providing to CMS is, you know, specific measures that's shown that there's evidence and we can address some of these being domains but in terms of what would be best practice. So for, you know, Medicaid plans where our population, we have a very, very high disparities in terms of our population for Medicare, low-income Medicare Advantage, and for the Medicaid population, what would you hold sort of accountable to the health plans as part of their programs and being able to write very specifically of what should be part of their care management program, what should be in terms of best practices. We were talking about pay-for-performance for your provider group. So being very explicit because that is going to be translated very well to health plans who are going to be helping to provide that structure.

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

So I could imagine a few paragraphs and call-outs to some existing resources. The part that hasn't been done yet is really essentially CMS being the audience because they have the big lever. So particularly the public reporting and the payment policy, I mean the money that drives everything.

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

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

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

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

So I think some of this is being very truly laying out, back to our term of a roadmap. There's a series of tollbooths along the roadmap, and so what can we do to get you kind of along that path but not have it be these measures come up. These measures come up. Frankly, none of them get submitted to us. It isn't even that the MAP doesn't pick them among all the measures submitted. None of them come forward and, frankly, because there are so few. But I think there's ways for us, just as an illustrative example, to be the teeth, to push harder and say how it will be done, as I think the rural committee did.

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

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

CO-CHAIR PONCE: And Kevin has been

waiting patiently.

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

This may be too specific, but I do think it gets at an issue of power and voice. And that's the concept of 360 evaluations in our own medical center. All the chairs and center directors have 360 evaluations in my own department. All the faculty also have them. And what that does is it gives staff who are below somebody in rank and pay a voice in the evaluation of that person and really helps to level that power differential in the sense that the person is included in that. It's a structural issue, but it clearly has impact on culture.

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

And just to give some specific examples, you know, if you want to get care, I know in Rochester, to figure out how much it's really going to cost, it's often very hard to do. You can sometimes go to some of the health plan websites to get estimates, but I know at my own institution you have to call a number and they'll give you an estimate. It's really funky and difficult. And so for people who are very concerned about cost because they may be low income, may be in a high deductible, they really have no idea of what it's going to cost before they enter. So the costs, the ratings of doctors, for example, the University of Utah Medical Center now is posting all of those cap ratings for their doctors online right next to their pictures. But, again, there's transparency in that information.

You know, ultimately, I think we all want transparency. That's a big aspirational thing down the road. Even transparency, for example, in assistance. In Hill-Burton, one of our MPH students a few years ago looked at how patients were informed about health about Hill-Burton in the Rochester community, and there was no systematic policy. Some people are told about what's available, some aren't. And I suspect that it's very similar in other institutions that there really is not transparency in what the criteria are and that you can apply, and all these things I think are critical to inform choices, particularly for people who may not have other sources or social networks to get that kind of information.

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

You know, the last piece, you know, this may be a little too -- we may not have enough data on this yet, but it may be worth putting as a bookmark, and I think there's pros and cons. But I think it does have some implications for low-income people, and that is sort of the converse of value-based payment, which is value-based design, which is that your design, you know, we reduce co-pays for things that we know are of high value. So, you know, if we believe certain medications are, you know, critical, there may be no co-pay for that. You know, in some countries, primary care, which, arguably, is essential, there's no co-pays for primary care. That's only been done in a few sectors in the United States. But, again, that would have particular benefit to somebody who's low income that they're not paying the same co-pays or having to meet whatever deductibles on their value-based design. I think it's worth at least bookmarking that for further thought and consideration.

CO-CHAIR PONCE: Thanks, Kevin. Ignatius.

MR. BAU: So I just wanted to say a few words about advocacy and policy because that's not something that we talked about. So I like the frame that we're developing again, the socio-ecological model. But if our premise is that inequity is based, in part, on structural reasons, then I think thinking about advocacy at all those levels, so advocacy for the individual patient and the patient's needs, the linkages, what's missing in the community that they actually need: is it housing, it is transportation? So at that individual clinical level, but I think also at the provider level of is it a school district, is it another provider that's not providing culturally competent care that, as a payer, you could do something about.

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

So I think we can also think about the

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

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

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

So for example, there's a shared decision model grant that's sort of like an add-on that an ACO could do right now. Why not create a similar kind of a grant-funded or incentive program because Medicare doesn't have the data, but I have it within our EHRs, actually. I can add to the colon cancer screening data, stratify it based on race, ethnicity, language preference, so why not create a grant incentive program, you know, some type of a model. Then they actually literally create the incentives for a provider to address these disparities, they give some examples. These straw domains could be strategies that you would write in the RFA. For example, they could be things that you could use to lower those disparities, and that will be something very specific and actionable for an FQHC or an ACO to actually start doing something to reduce disparities using the measurements that are already being used by MSSP. That's where I think a lot of these domains are already are broad measures, they're just not stratified, but Medicare could be and Medicaid could create incentives for us to specifically go after these and bring that into the accountability. So my ACO or Nancy's ACO could really start doing these and having some incentives to build the infrastructure to do some of this stuff.

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

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

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

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

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

MEMBER OGBOLU: Thank you. So I agree with much of what people have said already, and I'm happy to hear this discussion of kind of actual implementation, how is it going to happen, how are we going to push anything forward by the measures or whatever this process we are addressing. And to Helen's comment about being a roadmap and then maybe we could think about what it would take for people to get to toll one, toll two, toll three. So it sounds like the conversation kind of bringing up good ideas about how we could do that, so it's the how piece. I'm very excited about that.

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

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

If you're trying to improve colorectal cancer screening and the issue is that people are scared of or have certain attitudes about colorectal cancer screening, how you go about addressing that could include as a very specific example enlisting barbers to talk to their clients about the importance of colorectal cancer screening or hypertension screening, both of which there's a body of evidence around.

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

And so the accountability, as I think about it, can be thought of a couple of ways. It doesn't have to be everything that the health department does, but, as it relates to the domains that we're coming up with, what are the pieces that link back. I think that then makes it something that CMS can get its arms around because then that's about a suite of services that are trying to accomplish the objectives of CMS up to and including closing disparities. And while barbers are not going to be the selling point for me on why I should get colorectal cancer screening or hypertension, only because I don't need to be convinced, I'm already sold, that might be a strategy that makes a lot of sense. And I use that very, very specific example to say there's a body of evidence out there about the things that do make a difference, and we don't necessarily need to categorize them or catalog them, but we should at least speak to the use of evidence-based community-enabling services that might link to the very clinically-centered things that CMS thinks are important.

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

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

MEMBER BERNHEIM: So I just want to make sure I understood what you just said, which I think I did, which is that if you held the public health department or the local ACO accountable for disparities in colorectal cancer screening, part of the evidence you would use for having that be a measure is that there are interventions that work. So you're not holding them accountable for the intervention, you're holding them accountable for the disparity with the evidence that there are interventions. Is that your point? I'm trying to imagine the measure.

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

That ACO then has the knowledge of what is the menu of things that might work, and one would at least believe that that ACO would then put to use those things that makes sense in its community, which might include partnering with a health department or actually any other nonprofit. I use the health department. It doesn't have to be the health department. It might be an organization that calls itself the community health worker employment agency, and you contract with them, they're held responsible for their piece, but the accountable care organization is the one that's ultimately held responsible for closing the gap with all the different pieces that you have to put together to close that gap because even if the barber, if the barber convinces people they need their colorectal cancer screening and people line up and there's nowhere to get the screening, guess what? The rate doesn't change. You just activated people and you motivated them to do something, but you didn't deliver on the execution side. So the accountable care organization ought to be responsible for all the pieces.

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

CO-CHAIR PONCE: Yes. And Sarah?

MEMBER SCHOLLE: Just so I could add on

to that because in a measurement framework, then what are we measuring, okay? So are we measuring just is the gap closing and saying you're responsible for closing the gap, or are we also measuring whether the organization has structures in place for those community linkages? Do they have structures in place to know where the gaps are? Do they have structures in place that get at many of the topics that we've looked at, these capabilities? Because you might not be able to, first of all, you won't be able to see whether that gap is closing. It takes you some time for that to close, right? And so one way of thinking about this is to look at the way that the program, even the MIPS program is set up. Right now, the MIPS payment incentives say some of what we're going to pay you on is how you're organized, what systems you have in place, and some of what we're going to pay you on is actual achievement on quality measures. And so you could think about that, and by including some structural measures that get at how you're organized or what, you know, what data sources you use, those things can serve as measures, you know, part of a measure's roadmap that people could demonstrate in the shorter term before they actually get to the reductions in disparity.

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

And while we're on this, so, you know, when I think about this issue, I actually think the structural measures are really important because you want to see that there are some systems in place. There's, you know, some engagement of the community in their quality improvement activities, that there's some data collection processes that are real and complete and, you know, focusing on understanding the network and community linkages. But we fight. We have a number of arguments about how far we should go and what documentation is sufficient on how to define those structures.

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

But the measures that we have for looking at individuals' experiences of care may be another opportunity to think about this. And there's probably, there are way more items and tools available than are commonly used to capture experiences of care that get at things around cultural competence and literacy, and there are actually other tools that can be used to capture perspectives of individuals that are part of a team about how well the organization is really committed to these goals that have not been used. And that's another opportunity to think about as a data source for understanding something in between whether the structure is in place and whether the outcomes are achieved.

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

MEMBER FISCELLA: Yes, I can be very quick. I realize that I probably undersold the value-based design a bit because, as I started to think about it, I realized, of course, the ACA has value-based design built into it. I don't know if it's really called that, but that's what it is. And it starts, of course, with essential benefits, which was our, you know, there was a huge political battle over that. But it has to start with what's going to be covered.

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

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

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

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

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

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

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

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

So, Karen, are you on the line?

DR. JOYNT: I am. Good morning,

everyone.

CO-CHAIR PONCE: Good morning.

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

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

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

CO-CHAIR PONCE: Sort of.

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

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

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

CO-CHAIR PONCE: Yes, yes.

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

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

First, we learned that there are pervasive disparities across many, many measures and many different parameters of social risk. And, second, we learned that we have a long way to go in terms of data on social risk.

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

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

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

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

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

And they also pulled out health literacy, mostly for our benefit because it was listed in the law. And so they showed us the relationship between that, and what we don't have on this slide but, if you're interested in pulling up the report, they actually made a conceptual framework to sort of work through how each of these risk factors plays into individuals' interaction with the health system and then health outcomes.

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

So which social risk factors are most important to capture of those five factors and then of the individual measures that comprise each of those five social risk factors? Which of them have validated measures? Because it's always harder to measure things when you haven't figured out how to do it yet. Which social risk factors are stable over time? And this really leads to more of a data collection issue. Can it be a one-time data collection, or do we need to do it repeatedly over time? What data are currently available to measure social risk factors? Again, if data is already available, there's an ease with that. And then, finally, if it's not available, what's the burden of new data collection and really for whom? Is it on beneficiaries, providers, the Medicare program, or some combination of those three groups?

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

DR. YABROFF: Great. Thanks, Rachael. You can show the next slide. The National Academies did some of this work in thinking about some of those questions that Rachael posed for us, and I'm going to bring you briefly to this slide. So in the left most column are a list of the different social risk factors, and then the other columns provide an indication about data availability, and they've used a nice color-coding scheme. So the green indicates available for use now, the light green is available for use now for some outcomes but additional research is needed. The light red is not sufficiently available now and research is needed for improved future use, and then the dark red where research is needed to better understand the relationship with healthcare outcomes and how best to collect those data.

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

Other factors, like acculturation, is a dark red, so that is research is needed to better understand relationship with healthcare outcomes and how best to collect those data. Other factors like marital and partnership status, living alone, social support, those are more in the middle where additional work is needed, so not quite available for work now but not no or little information available.

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

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

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

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

DR. JOYNT: Well, if you wouldn't mind moving back to, I think it was the third slide. One more before that. There. You know, I think we are sort of grappling with some of these questions now, but if you have, if you have thoughts or ideas related to some of these, you know, which social risk factors are most important, validated measures, and burden of new data collection, I think that would be a really important topic for conversation.

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

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

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

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

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

So just the key takeaways. We're seeing more complete data at healthcare system and practice level than in health plans, but we're seeing tremendous variation in how patients are asked about social risk. So probably not news to anybody.

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

And I guess just to start with, you can see Medicare has less green. That's good. And what the blue means that there's complete data. So the blue, that's the percentage of plans reporting to NCQA who had complete data on race, ethnicity, spoken language, written language, other language needs.

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

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

Go to the next slide. Now, in our patient-centered medical home program, so currently 60,000 clinicians are recognized in NCQA's patients under medical home program. It's about not quite 20 percent of practicing primary care clinicians. And we do expect that practices have information on the diversity of their patient population. You can see that most of them do. And a lot of this is aligned with the expectations for meaningful use.

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

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

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

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

Go to the next slide. But it's all

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

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

DR. JOYNT: That would be terrific. That's amazing work to have that kind of detail around the specific ways that some of these data are collected. Certainly the future of measure collection, I would presume, is, you know, through electronic capture and sharing of those types of data, but that raises a host of questions going all the way from collection, as you point out. How are we even asking these questions and is that consistent, and then how can we share it in a way that's respectful of privacy? And then maybe most fundamentally difficult, how do we use those data, and are they most appropriate for helping us target interventions or for thinking about quality, or, you know, how do we even incorporate these data, presuming that we can get them in a consistent way, into how we think about policy.

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

CO-CHAIR PONCE: Okay. Nancy, then

Bob. Nancy Garrett, then Bob Rauner.

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

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

And so the way we are planning to approach that, we're really trying to coalesce around the IOM recommendations for electronic capture of social needs, and they have a question on general income instability or insecurity, and we're going to have some drill-down questions from that on housing and food and security, and we're going to start with the food and security question.

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

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

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

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

And then just in terms of other data sources to start to think about, we have done some work linking data from social services with healthcare. And, in fact, in Minnesota, we passed a law that allows that kind of data sharing. And I think there's a lot of information in the social services world, for example from HUD on housing, and I wonder if there are ways to use some of that data in a more national scale with Medicare that might be possible.

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

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

CO-CHAIR PONCE: Thanks, Nancy. Bob?

MEMBER RAUNER: Back to filling in the gaps of missing data, a lot of these things would be readily capturable within a clinician's EHR The biggest limitation that we have on the provider level is that the EHRs have very rudimentary abilities to do any reporting on the data within the EHR. So for example, you would think an advanced EHR would be able to pull up my list of a 1500-patient panel, give me a list of the diabetics, how many are out of control, and give me that list. Almost none of the EHRs actually can do that. It should have been one of the most basic population abilities of an EHR, and I think that's the single biggest failing of the ONC the last five years is they didn't do that.

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

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

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

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

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

So I think data sources for those social risk factors are the aggregate, looking at some of the CDC data collections. I know there are some communities in New York City I'm most familiar with that actually can drill down to the neighborhood level, very specific kind of community neighborhood-defined neighborhoods on those variables, and I think that would be an important addition to our work, particularly as it relates to the SDS trial period.

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

So I guess my question is, given this report, this series of reports, and data availability, what's the expectation given kind of the sunset of the trial period that the general kind of lack of use of these available data, according to the reports?

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

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

As you look at the NAM report, Karen, how many of those measures listed as being sort of potentially available or on the horizon could you realistically see getting kind of folded in particularly to the kind of CMS data that's typically used by Susannah and others to do some of the outcome measures? Any thoughts on that, Karen?

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

So I guess I don't see in the immediate, you know, like in the next few years that many of these things will be ready for prime time. One exception to that, actually, may be some of the area stuff. Our difficulty in the first report, and if you look at the results of that report you see a lot of odds ratios of like 1.01 for some of the area-level measures. And it's not that they're not important. It's that they weren't precise enough, so they tracked better with rural poverty than with urban poverty because the area that we used I think wasn't small enough to really get to some of the disparities that might be really important.

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

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

MEMBER ALBERTI: The question, the follow-up, is there a difference from our perspective in the oversight of this trial period between readiness for ability to be used tomorrow and actual measures or ability to be used in an empirical test even if the end is not a national sample? Is there some use in thinking about the empirical testing of these with the full availability of what data are available for 12,000 cases or 15,000 cases that might actually shed some light on the relationship going forward?

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

CO-CHAIR PONCE: And before I go to what's on the queue, I think that is an important question. You know, I run a survey in California called the California Health Interview Survey where we have a lot of these social factors, and we're also part of the National Network of State and Local Surveys, so issues like a question bank, you know, having the questions being very similar, is discussed voraciously amongst this group, and I think we also, another idea is, you know, we can't fund the survey to get the granularity of the ZIP codes the census tracks, and so we do small area estimation at the ZIP code level, but we can actually do it at the census track level. And that's the strategy that CDC is using for the 500 Cities Project, as well.

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

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

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

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

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

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

So I will talk a little bit, just briefly describe the two sources of socioeconomic data that we have looked at that Nancy referred to that is at a very granular level, nine-digit ZIP code, there are 30 million data points. You can get it at the person level. For a large percentage of the population they actually have this data at the patient level. That would require too many HIPAA, you know, rules for us. So we actually got it at the nine-digit ZIP code level. Average of five households. So, yes, highly predictive of patient health behaviors.

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

And we find some interesting things. I think I presented to you guys last year about medication adherence. So if you just use dual status or low-income subsidy status, you find that duals are less likely to be adherent to medications. When you add income, poverty, living in poverty to that equation, the duals actually do better than those poor non-duals who are right on the cusp and don't have those extra supports that the dual-eligibles have.

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

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

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

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

MEMBER IEZZONI: Wow, that's so interesting. It's so much fun to have actual practical information. Thank you, Christie. First of all, gender is noted to be 100-percent collected, but I would suggest that it's probably not actually, given the way that people often, especially young populations nowadays think about gender. And this is going to be a big disparities issue, especially if you're looking at healthcare for young people. So I would eliminate that 100 percent gender is collected because it may not be collected the way that it needs to be to look at disparities for people who are trans and other gender identities. So we need to think about that.

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

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

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

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

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

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

MEMBER IEZZONI: -- especially for some populations, it's not going to be sufficient. The second thing is I think that, and I say this with some caution, especially as undocumented individuals in the United States are increasingly facing confrontations with ICE agents, that willingness to reveal Hispanic or other identities that might not, might suggest that they may be undocumented I think is going to increase. And I'm not sure how long this is going to be in place, how long these kind of concerns will happen, but I know that people who are thinking about the 2020 census are already worried about whether some populations are going to be undercounted because of concerns about ICE agents knocking on their doors. And so I think that that's going to be something that I'm not sure how we put that in the report for CMS, but I just want to raise the issue.

Another issue is that we recently have completed a very intensive effort to collect data from people with significant physical and mental health disabilities, and we have found people do not like using online data collection. They want to speak to a person. And so they really, like five percent of people, and we had like 60-percent response rates on our surveys, including from homeless people. In fact, our homeless people had higher percentage response rates, but they wanted to speak to somebody. It was just that human connection, rather than going online. And so I think the increasing trends towards digital data collections are going to really leave out some populations.

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

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

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

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

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

MEMBER IEZZONI: I reviewed reports for

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

DR. YABROFF: Okay. Well, thank you.

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

MEMBER IEZZONI: I would not mind.

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

MEMBER FISCELLA: So these are really ideas for potential pilots to explore more and potentially CMS, you know, could do that. The first is use of the Z codes 55 to 65. And I could imagine where one could go through those codes and begin to say, okay, you know, we think that these are really important, could even affect the cost of care, and, on a pilot basis, begin to look at incentivizing or, you know, adding that on as an adjuster for payment in a pilot sort of way. That would do two things. One is it begins to incentivize collection and use of these codes now, and the second is you could look at its potential feasibility. And, ultimately, it's outcomes using currently available measures. And if you drill down, some of these are actually pretty detailed.

The second idea is, and this is really for the ONC, is that one could begin to use internal data within the electronic health record to create perhaps, there would probably be indexes. One would have to see if they really coalesce together in terms of measures. But every time, for example, somebody changed their address, you had a count variable with the date, so you could look at frequency of change and address, frequency of change in a home and phone, frequency where there was no phone available, insurance change or period where there was no insurance listed. One could even look at missed appointments and begin again to evaluate these as to what their impact was on other aspects of care, for example ED visits, re-admissions to hospitals, and other sort of relevant outcome measures.

CO-CHAIR PONCE: Great. Thank you. I'm going to go to Bob, but we also have some committee members on the phone, and so I'm queuing you up after Bob's comment.

MEMBER RAUNER: I wanted to add a comment on Christie's comment about why the EHR data is so bad. Essentially, it's because what happened with meaningful use, especially stage two and three, there's an exhaustive laundry list of stuff that providers saw as not valuable to them. So, essentially, they're doing the minimum amount to pass that meaningful use audit. And the way to move forward is to get past the laundry list of meaningful use and things like reporting, for example, because the projects we're working on with clinics is, once they start using the data, they clean it up really quickly. And so the problem is if you can report on it, pull it, use it, they'll clean it up really fast, and then it will become useful data for Christie and other researchers to get into it. It's the fact that meaningful use became the laundry list of bureaucratic requirements and there were no advanced clinical processes, which was the original intent of meaningful use originally. And so that's why our EHR data is so bad, but it could be great if we could fix these issues.

The other thing I want to add is about the immigration status issue is that in our community right now what's happening is our Hispanics community is really hunkering down and they're not wanting to share any information whatsoever because they're afraid IMS could be using that data to find them essentially. And so a lot of our community services, they're unwilling to, even things they might qualify, they don't want to give a name, they don't want to give an address, they don't give a phone number, and they're not spending money on anything because they're essentially saving for the storm. So it's going to get really hard to do anything around immigration status, I think, until politics changes in the next year or two.

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

MEMBER NERENZ: Nothing yet. It's okay.

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

MEMBER OGBOLU: Sorry. No comment.

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

MEMBER BERNHEIM: Hi, it's Susannah. Just a request that sort of echoes what some other folks have said. I think it will be really valuable if this report not only talks about the potential data sources but weighs in on two particular issues that have come up. One is this sort of interagency collaboration, as I think Nancy pointed out. There are lots of places where data is available, but there's often a lot of trouble. I mean, Social Security I think isn't even sharing basic death data with Medicare anymore. So if you guys can weigh in on where those opportunities are between agencies to make data that exists available, that would be one thing that would be really helpful.

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

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

CO-CHAIR PONCE: Thanks, Susannah. Romana?

MEMBER HASNAIN-WYNIA: Hi. This is Romana Hasnain-Wynia, and I was just looking at the red box under or the boxes under gender for gender identity and sexual orientation, and I just wanted to call out research that is currently taking place, particularly around the collection of both categories of gender identity and sexual orientation. So there is a study that is based at Brigham and Women's Hospital in Boston, the principal investigator is Adil Haider, H-A-I-D-E-R. And he is leading a study looking at patient-centered approaches to collect sexual orientation, gender identity information in the emergency department. Part of the reason for selecting the emergency department was because that was perceived as probably one of the most difficult places, given the intensity to collect this information.

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

And I know that Ignatius Bau, who's

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

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

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

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

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

MEMBER ALBERTI: Just a quick addition to that conversation about the collection of sexual orientation and gender identity. I believe it's UCSF that has actually changed their EHR a few years back and published how they did it, why they did it, what the question set is. So there's some evidence from that system that might be useful in this conversation, as well.

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

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

I did want to make a note on this issue that, just as we had the discussion about gender versus sex, my comment on the NAM framework would actually move biological sex into the gender category and move sexual orientation into social relationships because I think it's not a gender issue the way that this is framed, but that sexual orientation is more about who you're connected to, as opposed to who you're attracted to in terms of how it plays out in terms of the risk.

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

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

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

OPERATOR: At this time, if you would like to make a comment, please press * then the number 1. There are no public comments at this time.

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

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

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

And we've instituted a digital platform for our community health improvement plan and have engaged over 7,000 people and increased representation by 1000 percent. It's about five months old. And I just want to say that working together is the only way that we're going to be able to move anything at all, in our rural community especially.

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

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

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

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

And so we have something pretty cool in this area. So I'm waiting because I can't find any measures. And so, for instance, when we were talking about an issue in our improvement plan, like tobacco, let's say. We are the worst in the state for tobacco use, so what role does the health planner does? What role does the hospital have? What role does the school system have? And we have on this digital open forum these strategy cards, and so every organization is inputting their measures on how they're working on these certain issues. But it's all local level, and so I'm trying to find information on how to make that more evidence based.

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

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

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

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

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

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

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

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

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

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

So, I think we're going to shift gears a little bit here. And we have some questions for you about some of the issues that have come up from NQF's trial period where we allow our measures to consider social risk factors in their risk adjustment models.

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

DR. BURSTIN: Great. Thanks, everybody.

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

So, as an example, when the NQF board recently endorsed a set of readmission measures without adjustment -- because again the data available and the analyses, as done, did not show a significant difference -- the -- initially the Consensus Standards Approval Committee as well as the board came out with these four recommendations to attach to the endorsement decision. I just wanted to put these up there.

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

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

So, for example, if we began to put frailty or functional status into risk models, how much would we begin to see perhaps some of what we think we attached to social risk may really be about this unmeasured clinical complexity. And even just -- even on the clinical side, the idea that we're still using, largely, claims data to do risk adjustment without the level of precision you may need about, you know, levels of congestive heart failure, et cetera. It's pretty difficult to do.

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

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

Next slide.

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

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

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

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

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

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

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

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

And I will just cue it up for you and we'll come back at the end. Are there other unresolved issues as we sort of walk through this this afternoon that you think we should get some clarity on as we move forward?

Next slide.

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

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

We have not seen variables come forward that use these, with the exception of some use of some of the current population survey data in the AHRQ deprivation index. But even that is still fairly, you know, not necessarily just taking a community-level factor and thinking about how that weighs in.

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

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

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

So, next slide, please.

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

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

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

And then if you have a sense of how we should help with you over the next coming months, years, think about how to address the other unresolved issues. And I will cue up the question from the earlier page which is, are there any other unresolved issues you feel like we haven't captured?

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

CO-CHAIR PONCE: Thoughts from the committee?

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

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

CO-CHAIR PONCE: Bob?

MEMBER RAUNER: My question is, so a lot of this is based on hospital data because, you know, readmission rates, for example, is such a big deal for CMS. But one of the problems is that all that data is all most often just Medicare-based claims data, for example. But the people working with the most disparate populations rarely have people at federally qualified health centers, for example. There is a lot of data within those FQHCs in our -- we have some Nebraska projects where you can look at screening rates by ethnicity and insurance status, and you're seeing huge changes. But I've never seen much published in that area.

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

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

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

We talked very briefly, you know, thinking about what it would mean to find jurisdictions or states or communities that actually have comprehensive community data available. So even if we can't conduct, you know, an empirical test based on nationally representative data, I think certainly some of our empirical models could be assessed, you know, whether it's in New York City or in California, or places where we know they're spending the time and the money to do the kinds of over-samples of BRFSS data or YRBSS data that allow you to get -- to drill down more than a 5-digit ZIP Code or even more than a 9-digit ZIP Code just to see if some of these constructs that we -- I think we would all draw very similar conceptual models for readmissions on the kinds of variables upstream in communities that would lead patients to be more likely readmitted, whether it's social isolation, whether it's lack of heat and hot water, lack of food access, lack of transport. I mean, we know these things have impact.

So, if there are places where we actually have good data that could be matched to hospitals -- I think about is it possible to get a coalition of New York City hospitals together? Thinking of combine their data, look at neighborhood level data, and run some of these tests that could at least inform the aspiration for an eventual kind of robust adjustment that includes both clinical risk factor, patient-level social risk factor, as well as neighborhood and community risk factor data.

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

CO-CHAIR PONCE: Thank you. Bob?

MEMBER RAUNER: A follow-up to that, has anybody reached out to HRSA? Because the UDS measures are all migrating toward NQF measures. And every FQHC in the nation submits all its UDS measures to HRSA, I think, quarterly. They've got demographics in all the FQHCs. You could probably link them back to the local hospitals that work in their catchment areas. Maybe it's a silo problem where you've got, you know, NQF here, CMS over here, HRSA over here. If they got together they could -- they might be able to put some of this stuff together.

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

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

CO-CHAIR PONCE: Yeah.

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

CO-CHAIR PONCE: It is aggregate.

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

CO-CHAIR PONCE: Yeah.

MEMBER RAUNER: -- FQHCs is patient level actually.

CO-CHAIR PONCE: And Kevin and I worked

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

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

And so you're already kind of into this pathway of defeating the argument that social factors matter. And I will need to read the ASPE report more carefully, but in the presentations that Karen has presented -- not just today but I think about a month or two ago -- it looked like they looked at social factors first. So, they looked at the relationship with social factors put in first. And then they brought in the others.

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

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

MEMBER GARRETT: So, you know, in terms of the question about hospital- and community-level factors, I guess my opinion is absolutely they should be explored. I mean, as a member of the SES Panel, I don't think we intended to exclude those from the report. I think it was just that we ended up focusing a lot on individual factors because we were looking for the characteristics of the population that would be not actually measuring quality of providers but measuring something else.

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

And so if a hospital-level variable would meet that -- for example, if you were looking at payer mix as a possible adjuster -- maybe that would be confounded with quality of care in the sense that hospitals with more Medicaid patients are going to have fewer resources to address the variable and, therefore, have lower quality. So, in that case you might decide not to use it as a risk adjuster but it might be a really important variable from a health equity standpoint of are we getting the resources to the right place, right.

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

So those are a couple of thoughts about that.

And in terms of the question about whether it should just be outcomes of variables, I really like the construct in one of the National Academy of Medicine reports of the idea of categorizing measures for whether they are social risk factor sensitive or not. And I think that might be a more useful frame so that you might say, okay, if measures based on conceptual -- kind of the model that we have, not necessarily based off the literature just because we don't have good research on all of this -- but if conceptually there's a strong relationship to social risk factors like a diabetes outcome measure, then we might say, okay, that measure we really do need to look at risk adjustment.

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

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

CO-CHAIR PONCE: Thank you. Lisa.

MEMBER IEZZONI: Thank you.

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

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

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

And, Helen, remember the days 20 years ago plus when Arlene Ash and John Ayanian and you and I and David Bates worked together on the PIP-DCGs? Remember those? Well, Arlene is still working in this area. And she actually had a contract with the state of Massachusetts to use information about a person's eligibility for some of the state support programs -- for example for mental health, and so on -- and using that in risk adjustment models.

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

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

I just want to point out, it wasn't intended that those were the same questions. It's just the question for you is consider hospital, consider community, not together. And I fully recognize you may walk out of this room with very different answers to both of those. So just wanted to tee up both of them as being unanswered.

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

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

CO-CHAIR PONCE: Sarah.

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

So on the hospital, I think there is

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

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

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

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

And then for NCQA measures we tend to push as much of the data to the health plans to do the calculation. And so it really depends on how that reporting is happening. There's a lot of room for error. And the more complex the measure, the more challenging it is to get apples to apples comparisons. So that's another issue to consider in how we take into account these factors.

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

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

So as I think about hospital factors, it may -- it may suggest approaches to fixing the disparity as opposed to adjusting for the disparity. And the same goes for the community.

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

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

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

CO-CHAIR CHIN: Let me jump in for a sec. So, Eduardo, my dad taught me that when someone starts a question by saying this may be a naive question or a stupid question, these are the guys that have the really smart questions.

MEMBER SANCHEZ: Able to fool you on all fronts.

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

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

MEMBER SANCHEZ: Totally agree.

CO-CHAIR CHIN: So some of us have a question that the issue you bring up and Nancy brings up, in some ways starts tying into the next charge we have of, like, the policy part of this. And one of the things that made the committee -- the last committee hard was that there was that firewall and that we just couldn't think about then the full panoply of tools of recommendations, which now we do.

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

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

DR. BURSTIN: Absolutely. So this is very much -- teed this up around the concept of our trial period. And, again, depending on what we wind up doing with it moving forward. But these are issues we have encountered, as the measures have been submitted as part of the trial period, to consider for adjustment. So that's why this is adjustment framing. But this committee is free to think about it, and I think one of the key open issues is going to be, you know, do we move forward with recommendations that move beyond, you know, adjustment as the only approach?

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

And just to remind us, with your guidance what we actually wound up doing is that as measures are submitted for the trial period, if they are adjusted, we require that the specifications include both the adjusted measure plus the stratified specifications because we do not want to get into this issue of masking.

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

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

But feel free to think broadly.

CO-CHAIR PONCE: Christie.

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

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

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

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

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

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

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

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

Now, when you look at the risk scores

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

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

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

So, you know, adjusting for clinical risk factors would take -- it would get some of that, you know, risk score -- higher risk score, higher complexity, higher burden of illness. But even when we do that, we still do find that poverty has an effect, dual status has an effect.

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

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

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

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

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

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

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

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

Nancy.

MEMBER GARRETT: Just to follow on your

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

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

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

CO-CHAIR PONCE: Dave.

Oh, Susannah joining then? Oh, she's on the -- oh, Dave or Susannah or Yolanda. Let's go with Dave first. Let's go with Dave first, then Susannah, then Yolanda.

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

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

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

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

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

The reason I think our group a couple years ago now got to the point we got to is that when you think about, particularly outcome measures -- this is not so much directly relevant to process measures, but certainly outcomes -- if you just draw it out -- and I have to kind of do it in the air here, but maybe somebody in the room could do it more concretely -- you know, draw a classic boxes and arrows diagram where you've got the outcome on the right-hand side, and then you've got a bunch of arrows feeding it. I think what our group -- and we had this in front of us a couple times -- that quality is one -- and I emphasize one -- of several boxes that then feed the outcome. It's not the only thing.

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

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

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

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

CO-CHAIR PONCE: Thanks, Dave. Susannah.

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

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

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

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

So we can stratify the patient groups in our hospitals to understand the hospitals and if there are differences in the outcomes or the processes for one group of patients in that hospital compared to another patient in that same hospital. That's a version of stratification within a hospital or a plan.

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

Two clarifications. I have a question for the group if you guys have bandwidth on -- on the community factors issue what we run up against is as you really choose kind of the community factor there is, as someone said, huge evidence that a patient's community affects their health. But if I'm going to account for that, I really have to do location because you know two hospitals can be co-located in the same community but one of them may have many patients that are coming from neighborhoods that affect health. And one of them, even though they live and they work in the hospital's community, they have very few of those patients. So if I enter the same community for both those hospitals, I'm not capturing that neighborhood impact on an individual's health.

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

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

So back to you.

CO-CHAIR PONCE: Thanks, Susannah.

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

Yolanda.

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

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

And it's really interesting because the racial disparity that we normally see in national samples was attenuated when people lived under similar conditions. And so they controlled actually for the community in which people lived in and focused a lot on place. And then also compared people that had healthcare in the same marketplace. And I just think that was very interesting, that sample strategy was to search for communities that had 35 percent African American, 35 percent white, and looked for people that had similar median incomes, as well as graduation rates. And they were able to find 425 different tracks across the country that met that inclusion criteria.

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

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

Philip.

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

And, Susannah, I don't know if I got everything. The connection was a little bit scratchy, so forgive me in advance if I'm responding to something you actually didn't say or imply.

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

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

So when I was kind of hoping that we could think about ways to test some of these community-level factors I really meant the aspects of a community that individuals carry with them where variables are not necessarily defined by the aggregation of patient-level variables, but really variables defined at a community level where the patients themselves are being discharged to.

CO-CHAIR PONCE: Thanks for the clarification.

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

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

Does that sound on track for now?

CO-CHAIR PONCE: Yes.

DR. BURSTIN: Okay. Good, okay.

Kevin, were you going to say anything? You were about to lift your thing?

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

DR. BURSTIN: Yeah.

MEMBER FISCELLA: -- great, informed decisions here.

DR. BURSTIN: For both you think?

MEMBER FISCELLA: Well, particularly for the hospital.

DR. BURSTIN: Yes.

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

DR. BURSTIN: Yeah. And actually just raising that point, a point both Sarah and -- I'm sorry, that Susannah and Philip both raised earlier as well, is what if you only have community data on a subset of patients, is that something still viable to consider as part of the modeling? Thoughts on that?

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

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

The hospital I think is the worst place to do population health. It's the neighborhood is where you do population health. But everything seems to be driven by the hospital because that's where the money is, you know.

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

CO-CHAIR PONCE: Thanks, Bob.

Traci.

MEMBER FERGUSON: Yeah. Just to answer Helen's question about whether you could use a subset. I think that if you look at the subset of that population, if that aligns with or you could generalize the population that is treated at that hospital, whether you're looking at overall claims data in terms of diagnoses, in terms of the use of community resources, that you should be able to use a subset of that population. Shouldn't say, you know, you want to be, you know, have enough power within that sample size in order to make, you know, make decisions, and to see if there's, you know, statistical power.

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

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

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

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

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

(Laughter.)

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

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

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

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

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

CO-CHAIR PONCE: Yeah. I think that's -- I share that fantasy. So because I think it is more about local, or doesn't have to be the federal/national data sets that have, as we saw in one of the reports cards that we saw, had so many missings. But if there are data systems that get more at community-level effects, that those should be considered.

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

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

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

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

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

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

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

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

But because there are so many unanswered questions without a lot of clarity on some of these issues, some of our standing committees have been forced to make decisions maybe not with a full array of some of this information. So we'd be delighted to share it with you as we move forward.

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

Should we transition maybe to the --

CO-CHAIR PONCE: Let me just check.

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

(No response.)

CO-CHAIR PONCE: Okay.

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

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

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

So with that, next slide.

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

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

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

And so prior to this we had actually not allowed social risk factors, SES kind of factors as part of risk adjustment for fear of actually masking disparities. It was actually written explicitly into our validity criterion that we would not allow these measures -- these factors to be included. And we only allowed for patients' clinical factors present at the start of care.

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

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

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

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

Next slide.

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

Next slide.

So, at this point we have now asked all

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

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

Next slide.

So, we have certainly, as is

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

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

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

And we have continued to try to monitor progress on anything we can do in this feel. So, for example, Karen Joynt has been incredibly generous of her time and presented the full ASPE findings, for example, to our Consensus Standards Approval Committee, to our Measures Application Partnership, to you, to make sure we know what's going on. We shared all the NAM reports as best we can as well.

So next.

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

Although each time that has been brought forward the argument has been it's not been brought forward as a proxy -- and we've talked about this in the committee for SES -- but, instead, because in fact some of those differences are larger than what we're finding in terms of social risk factors, the developers, in particular Yale, thought it was important that people actually see those differences. But we have not, for example, seen any of the sort of further evidence for our neighborhood deprivation or any of these other community-level factors.

Next slide.

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

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

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

About how many have we seen, Erin, total?

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

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

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

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

Okay, next slide, please.

So, as we've looked at it, our approach has been thinking about a couple of key questions to explore. And, again, this is we're still in the midst of doing the data collection. So this is an opportunity for you to say are these the right questions? Are there additional data elements we could be gathering as part of this work?

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

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

Which factors and variables are being used?

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

Next slide.

We are also going to try to, in addition to just collecting what's been done to date, our thought is we are going to actually survey both measure developers who have had to do the work with filling out these forms and giving us their information and trying very hard to find data -- to give us some more qualitative information.

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

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

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

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

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

Next slide.

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

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

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

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

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

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

CO-CHAIR PONCE: Nancy and then Bob.

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

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

And so that, I think that's not -- that's important but it's not enough. It's really what is the logic model of how this outcome measure -- what influences those arrows that Dave was talking about? They'll be able to tell you about what are all the things that influence this outcome measure other than clinical process of care and do we need to be accounting for those.

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

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

So, just a thought.

DR. BURSTIN: And, actually, in terms of the evaluation plan it keys up for me that something we should look at is also what was the source of the conceptual model feature of the measure submitted to us. So, thank you, that's a great suggestion of whether when it's pure literature versus conceptual basis, by whom, based on what. Great.

CO-CHAIR PONCE: Bob.

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

So, can we take diabetes poor control, blood pressure control, breast and colon cancer screening, which are big impact measures within that, and then apply the same type of effort that was put into looking at whether the 30-day Readmission Rule should be addressed or any of that. So because I'm pretty sure there's very big differences. And I think we are going to see that people get dinged inappropriately.

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

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

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

Certainly support Nancy's comment, and also I agree that the whole MIPS domain is going to be important. I've got a paper that just came out that sort of speaks to that from kind of one perspective. I can attach that and send it around to the group, if you're interested in that.

CO-CHAIR PONCE: Yes. Thanks, Dave.

Philip.

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

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

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

However, we have some studies with finer data sets like Christie's, and it does seem that when you have -- benefits it does -- social factors do matter more. But we're not going to have, like, that exist for a while. But I'm wondering if part of I guess the solution may be we have this latitude then to make other recommendations. So, I mean, right now, for example, we're seeing that, well, yeah, we should keep on doing the trial period, we need better data sets.

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

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

CO-CHAIR PONCE: Great. Thank you.

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

phone.

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

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

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

DR. BURSTIN: That's a great point, Kevin. And you tee up another issue that has come forward which is that, you know, we'll say significant effect -- and Susannah can certainly speak to these -- some of these variables that have been put in their models, for example for duals, are significant, but the effect size is really small. And one of the issues that's often brought up is, well, we're saying it's not an effect overall, but are there certain -- you know, again as we think about this in the context of public reporting and payment -- are there some potentials within that distribution for whom even that small effect could have a significant impact? And how do we factor that into our thinking about adjustment?

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

DR. BURSTIN: Right.

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

Susannah, I hope you can still speak. I know you're on the train, but.

MEMBER BERNHEIM: I am on the train. I'm going to speak slower and hope you can hear me a little better.

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

CO-CHAIR PONCE: Great. Thank you.

And, Yolanda?

MEMBER OGBOLU: I have no additions as well.

CO-CHAIR PONCE: Thank you. And Dave.

MEMBER NERENZ: I'm okay.

MEMBER BERNHEIM: Sorry. This is Susannah.

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

CO-CHAIR PONCE: Okay.

MEMBER BERNHEIM: Which is I think that this question of how quality figures into disparities is not always incorporated into the conceptual models. And it's a really key conceptual question. So, this is sort of a micro point, but if we're going to give more guidance, part of our guidance might be not just about data and empiric analysis, but I think we could also give better guidance on thinking about where quality fits into conceptual model.

CO-CHAIR PONCE: Great. Thank you.

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

Kevin.

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

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

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

CO-CHAIR PONCE: Thank you. Emilio.

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

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

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

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

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

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

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

And Philip, if I call on your suggestion of equity-sensitive measures I think is a good one. I think it's what I think the ASPE folks also suggested we could do. I think we should proceed with caution, though, because it becomes a catch-22 with data, because if we don't, we may miss important health-equity sensitive measures because there is no data on that. So then we might miss out a whole -- when we start narrowing we may miss out on interventions that may actually be needed that are unmeasured.

Philip.

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

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

And I think part of the other piece is that even kind of the small effect size of the social risk factors notwithstanding, there's still a larger effect size in some of the clinical risk adjustments that are kind of rather uncontroversial. And so I think it's just a per organization and understanding what is a statistically significant finding, a clinically significant finding, a monetarily significant finding? And I think there are different definitions.

CO-CHAIR PONCE: Thank you. Emilio.

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

DR. BURSTIN: And some of the work, I think Marshall even co-chaired when we did the work around disparity sensitivity before. We'll be bringing back to you for reconsideration and maybe tightening some of that up. But I actually prefer equity sensitivity than disparity sensitivity actually. Bringing it as a way of positive instead of negative. That's interesting.

CO-CHAIR PONCE: Thanks, Emilio.

Oh, Christie.

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

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

And the other thing is the cut points that CMS uses, for example, for four -- two, three, four, five stars -- right -- are very, very tight for some measures, like medication adherence measures. Those measures have cut point ranges of two or three points to go from a 3-star to a 4-star to a 5-star because they're very, very tight. Everybody does pretty darn well on medication adherence. So a tiny difference can make a huge difference in those plans and the ability for them to be 4-star and get those bonus payments.

So it's not trivial.

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

So, you know, again, insights here for what you could potentially offer to our committees or how to consider analyses like that, how to consider different kind of statistical modeling even, that could -- I mean that's one of the unanswered questions, I think. As we've seen different developers come forward with different approaches, sometimes finding significant effect, sometimes not, how much of that is driven by the data, how much of it is driven by the outcome, whether there's a large effect? How much of it is driven by the statistical approach? And how much of it is driven by just some of these a priori assumptions going into the modeling?

So, your guidance here would be very, very helpful for us as well.

MEMBER TEIGLAND: And if you do the decomposition analysis so you're just analyzing that disparity, not the overall population, you do see those effects being much larger. So the decomposition analysis gets you, you know, a lot, buys you a lot more in terms of really seeing the impact, the full impact of those effects.

CO-CHAIR PONCE: Thanks. Bob.

MEMBER RAUNER: Along the lines with the hospital, there may be a way to run like a sensitivity analysis for a Medicare shared savings program, ACOs, and hypotheticals. So like, say, it's a plan with 10,000 patients, $80 million in Medicare costs, if this plan's quality measures because of their sociodemographic breakdown their measures are 5 percent lower, how many points does that mean they lose? And if they should get savings, what does that cost to them?

You might actually find out that what might be somewhat small differences like let's say your colon cancer screening rate was 65 percent versus 75 percent, how many points do you lose and how does it affect your calculation? It could end up being something fairly trivial or it could be something that costs an ACO hundreds of thousands of dollars such that if this ACO happens to work in an environment that's challenging versus, you know, working in a wealthy neighborhood, how would that affect them?

I think it's possible you could kind of run through some hypotheticals because those point scoring systems are all published, all out there, it's something you could put into analysis and figure out. Because I think it's, you know, within the hospital, you know, dropping 20 points on that you could be talking millions of dollars. It may sound like it's 0.13 percent, but what does that really end up meaning at the end of the day? And so does that ACO that serves, you know, Hennepin County, does it lose hundreds of thousands of dollars of funding because of this?

I think that's where this could help at the ACO level just like applied at the 30-day readmission penalty level.

CO-CHAIR PONCE: Great. Thank you.

MEMBER BERNHEIM: Could I say one thing about the Medicaid adherence issue.

CO-CHAIR PONCE: Sure. Go ahead, Susannah.

MEMBER BERNHEIM: I'm hesitant to raise this, but it's one that gets at me every time it comes up, and so I just want to use it as an example of where what I hear that the empiric data is strong, but I worry a lot about the conceptual model because I feel like there's pretty good evidence what we do as physicians influences adherence. And if we are seeing plans with more patients with adherence, I would want first to look deeply at whether we're thinking about what they can afford and what kind of medication regimen we're putting them on and how we're checking in about the situation.

And I worry that, in fact, in that case what I think it is doing us more harm. It may help the plan but I feel like it may be exactly my concern about us not deeply thinking about a conceptual model and their quality and our actions feed into those disparities.

So just food for thought.

CO-CHAIR PONCE: Okay, thank you.

It sounds like a lot of what we're heard, Helen is for moving forward. Not necessarily because, I mean, the trial's done or will be done soon, and so we did ask for sensitivity analysis. We did ask for looking at what significance means, not just statistical but clinical and payment indications.

DR. BURSTIN: Yes, this was great input. I think as we start pulling the data together to bring you in June we'll start maybe pinging a lot of Ninez and Marshall to make sure we present it in a way that's most useful. I've heard a lot of great things we could do. But I'm not sure they're directly related to the evaluation of the trial. But I think they are more a question of what we do next, do we build some of this in.

I do think it would be really interesting to build in maybe a couple of case examples of if you took a particular area and you tried to walk it through a full conceptual model and you look at the data available, maybe just even a couple of case examples might make it really useful, I think for the evaluation discussion in June.

CO-CHAIR CHIN: Down memory lane. I remember there was a Lisa Iezzoni paper from maybe 15 years ago, JAMA paper, hospital mortality.

MEMBER IEZZONI: More than that.

CO-CHAIR CHIN: Yeah. So the same story, like five different risk adjustment models, depending upon which model you used the rankings of individual hospitals changed quite dramatically. But it shows, I guess, the practical implications then of your choice of different models and then the value judgments you make with each model.

MEMBER IEZZONI: I think it was more like what Christie said. That it didn't change that dramatically, but for some in the middle it might have.

DR. BURSTIN: Could you say that into your microphone?

MEMBER IEZZONI: I've said enough.

MEMBER TEIGLAND: She said, yes, what I said.

DR. BURSTIN: Those on the phone, she said what Christie said.

MS. O'ROURKE: I think now we are going to shift gears again a little bit and talk to you and get some input about the upcoming environmental scan for measures that we'll be performing. So Drew's going to give some background about what that's going to cover and some areas we need some guidance from the committee.

DR. ANDERSON: Sure. So this really ties into the next steps and the purpose of the third interim report.

So, now that we've discussed some of the important areas for measurement we plan to use, once we have synthesized everything and, you know, and once you have submitted your homework we will be using the domains of measurement to do this environmental scan to see what the landscape of performance measures and measure concepts look right now. So, how can we map existing measures or best practices to these domains of measurement?

And so, for our approach we will follow a similar approach to what we have been doing in terms of looking for evidence. We will be doing a literature review, but mostly focusing on measure repositories. So ones that you all are already familiar with, so like the health indicators warehouse, the CMS measures and inventory, the AHRQs and, of course, our own measure database.

We will also be conducting a couple key informant interviews with other committee -- the co-chairs of other committee members within the target conditions that we've been looking at so far, just to get a little bit more insight about what measures might be most important to include in the scan. Because these measures are really supposed to represent what rises to the top and, hopefully, the best of what is available.

And I think Helen mentioned this a little bit earlier, we plan to use a modified version of the NQF's disparity-sensitive criteria that was developed back in 2012. It doesn't quite fit perfectly but there's a lot of lessons that we plan to learn from when developing our approach. So really there are two tiers to this. And I'm not going to go into too much detail because we do have to kind of adapt it to this project because it goes beyond some of the risk factors that they looked at originally.

But like the first year, just for example, the prevalence is really looking at the level of or whether or not the conditions is important for disparity. So we already have a set of conditions that we're looking at. Also, the quality gap is there, large disparities for -- that the measure can detect, and then the potential impact.

But and then there are also the criteria.

So, again, I'm not going to go into the detail of this, these criteria, but we can share, if we haven't already, share the report from 2012 for you to look through.

CO-CHAIR CHIN: Just to clarify then, Drew, that's like the third part here is the map to a practice which the closest to like the past two day's work would be mapping like to the different domains that were mentioned.

DR. ANDERSON: Right.

CO-CHAIR CHIN: So is that part of the test then to see -- of all the stuff we talked about, like, during the past couple days, these different domains, what measures, if any, exist then for these specific areas?

DR. ANDERSON: Right. So we would look at the interventions that are within the domains that you've identified. And for the ones where there -- and another thing that Cara had asked us to do was to look at gaps in research. So for the approaches that you all have identified where we haven't been able to find evidence for or few evidence for, it does set up a good case for us to say we need more investments in research in this area.

So, yeah, that does tie-in to mapping the domains and the interventions to measures.

But essentially what we wanted to do at this time was to just get your feedback on potential areas that we should be looking for measures beyond these usual measure repositories in the literature. And I know that you all have actually mentioned a couple measures' resources throughout the meeting, but if you have any ideas it would be great to get your feedback.

That was a threshold for the gap, so the amount of disparity between the reference group and then the population with social risk factor.

DR. BURSTIN: It was actually an empiric decision as to whether it was a logical break in what we could find. But, again, all these are open questions. So if we want to move this forward, we would love your guidance on sort of really building it into something we could use.

And I love the idea of rather than mapping it to one of our practices, many of which I think will still be applicable, thinking about how it maps to the domains is just such a logical way to frame this going forward.

CO-CHAIR PONCE: Ignatius.

MR. BAU: So back to the comments about not generating a whole new set of measures that may not be aligned to what might be going on. I think at some point it may be a futile exercise, but to map it to MIPS and to vital signs and this new Core Measures Collaborative that AHIP and CMS have come up with. And, again, it may map so that there are no measures that this committee focuses are that are in any of those sets. But even that, I think, would be an important communication to say we're completely outside the domain of where everybody else is.

DR. BURSTIN: That gets back to Bob's earlier point of could you pick the really high profile measures that are repeatedly used across the board. And maybe our explanation of this is even examining a very high profile set of measures repeatedly used across federal programs, how does this play out?

MEMBER RAUNER: That's why I asked about the 14 percent is because if you use blood pressure control and there's a 14 percent absolute difference between this group and this group, that could be a huge difference in mortality cost complications. So that's why I was asking why 14.

CO-CHAIR PONCE: Thank you. Nancy and then Romano.

MEMBER GARRETT: I'm just struggling a little bit with looking at the domains we came up with and then looking at these criteria. And I'm just not sure that they fit. So is the idea that this disparity-sensitive criteria would only apply to existing types of performance measures and not the new stuff we came up with?

DR. ANDERSON: Right. So that's why I said that we will have to retool this a bit for it to be more applicable. We are going to be looking at all measures that map to the domains that the committee identified. But we will also be looking more broadly at these more disparity-sensitive ones as well, just to -- it's kind of we wanted to just kind of put this out here as a tool that we can use to think a little bit more broadly.

CO-CHAIR PONCE: Romana. Oh, I'm sorry.

CO-CHAIR CHIN: Yes. In some ways it starts with the issue of prioritization. The work on that prior committee, the Disparities Committee, was kind of a mixed bag in terms of like you got some interesting ideas out there, but ultimately I think was limited and unsatisfying.

But I think beyond what we talked about over the past couple days are some of these issues of like population impact. Because prevalence of the condition, the relative morbidity, is there something you can do about the item at all. So things that I think some of the complementary to the domains we talked about, but the domain part would need to be, probably an important part of it that was just questioned a little bit in the third box here on this old committee diagram.

CO-CHAIR PONCE: Romana then Sarah.

MEMBER HASNAIN-WYNIA: So this is just, again, since we're, Helen, I think you said that we can think about retooling this. So I'm looking at the disparities quality gap, and I understand that was the threshold, but I'm looking at the word gap. And I'm going to come back to improvement versus gap.

So, for example, if we think about individuals with sickle cell disease, it's going to be really difficult to measure gaps; right? But we know that there are equity issues. And we know there are equity issues around pain control and a number of other metrics.

So if there's a way that we can capture, maybe within the context of equity, I'm not quite sure how to get there. But I think you get my point.

And there was something that Sarah said earlier -- I can't remember what it was -- but it also triggered, it was something about the within-plan disparities. So if we think about improvement, another way we can think about improvement is not just, you know, rising tides, but also if we look at national metrics, quality metrics where we expect a certain level of high quality and we see that there are disparities across different groups, that may, that may be the gap that we're trying to close if we're, you know, staying within the gap, the disparities gap framework.

But my proposal is to include both kind of an equity metric as well as a disparities gap.

CO-CHAIR PONCE: Thanks, Romana.

Sarah.

MEMBER SCHOLLE: Drew, for this work are you focused on the conditions that CMS specified?

DR. ANDERSON: Yes. Yes. So, we are using the conditions to bring up the example measures that fall within the domain areas. And I should have said that the measures are -- I guess what I'm trying to say, they're more it's going to be a very, like, illustrative example. Because there are so many measures, this is a way for us to prioritize the number of measures that would come up in these areas.

So the conditions will allow us to do some of that prioritization too.

MS. O'ROURKE: We were also thinking, particularly in the domain around quality, the selected conditions could be important case studies where there will be a lot of the traditional structure process outcome measures that we might want to apply these criteria and determine which are the most equity sensitive within those conditions, given that the universe is large once you go into the quality domain.

But I think we want to go a little bit broader throughout the other domains and see what cross-cutting equity measures could exist.

MEMBER SCHOLLE: So did CMS share with you the environmental scan that NCQA did maybe over a year ago? Have you seen that?

I will mention to --

MS. O'ROURKE: Yeah, that would be -- if that could be shared, that would be wonderful.

MEMBER SCHOLLE: Right. Because I think when you look at things that there's a -- I see how these are different, but I think that might be helpful to you.

And in some domains they're not condition-specific so, for example, patient experience, is that's not a condition-specific topic area but it may be an area of particular interest, particularly around cultural competence or literacy or there are questions about mobility that would get at some of those issues, again, that are less about a disparity and more about an equity issue.

So it might be helpful to pull that in. I don't think the world's changed that much since we did it about 18 months ago.

DR. BURSTIN: And the prior time we did this it was not limited to a set of conditions. It was really a way to look across the entire portfolio and say which measures were particularly disparity sensitive and should always be stratified.

But it is interesting now, looking through the lens of conditions picked specifically because they have disparities. We'll have to think through how useful that might be.

DR. ANDERSON: Yes, but that's a very good point. We'll definitely look more broadly at those measures that kind of cut across conditions, too, that apply to the domains.

CO-CHAIR PONCE: Any comments from those joining us on the phone?

CO-CHAIR CHIN: So I'm wondering, like, it looks like we have a little bit of extra time. And Susannah had a suggestion I think a little bit earlier about, a great one, if we have a few minutes to brainstorm, her point being that people made a number of really good comments that don't necessarily fit into the exact topic of today's meeting about domain selection and whatnot, but are going to be relevant, particularly for the end goal in terms of the recommendation report and all.

An example given like Romana's, where she just went on again in terms of closing the gap versus raising the absolute level type of thing. If we have a few minutes, if people can think about, like, over the course of a couple days, or their own comments, are there any things that you would want us to put in the parking lot so the staff can record it now so we don't lose it so that we can come back to it as we go into a report for it eventually.

So a few minutes maybe for people to start thinking about that.

If you're still on the call, Susannah, you mentioned you had three that you were going to share. So if you are on the call, what were your three?

MEMBER BERNHEIM: Yeah, I am. I'm pulling them up. I'll see if they still seem relevant.

So the one thing that I heard people say a lot that I think is worth just naming is that addressing the impact of social risk factors may take extra resources. It's embedded in some of our domains but I think it's an important concept that keeps coming up.

One is that the way I was framing Romana's point was that, you know, it's most important to include overall care quality and outcome. That you can't just prioritize improving disparities without an examination of performance and outcomes for the vulnerable population. For populations with social factors that influence health.

And then the third one was that both within and between disparities, both within and between institutions for regions or systems, are both important to examine and incentivize reduction. Those are the principles that I thought I had heard a lot over the last couple days that were worth kind of calling out in our report.

CO-CHAIR PONCE: So, Susannah, I heard two, not three. And the first was that you agreed with Romana about looking at overall improvement.

And the third was focusing on within and between disparities.

And I think I missed --

MEMBER BERNHEIM: Oh, the first one actually just this concept that I think it's worth us ceding that addressing disparities will take additional resources.

CO-CHAIR PONCE: Addressing disparities

will take more resources Marshall said.

CO-CHAIR CHIN: Yes.

CO-CHAIR PONCE: Okay.

CO-CHAIR CHIN: So thanks for starting, Susannah.

Do others have things they want to add based upon either their own thoughts or things people have heard over the past couple days? Sarah, no?

Nancy.

MEMBER GARRETT: You had just been saying a little bit ago, Marshall, about risk adjustment as one tool to try and level the playing field in that sense and make sure we're getting the resources the right places to reduce disparities and improve health equity. There are lots of others.

And so I really hope our committee speaks to those others and gets practical about what sorts of things can we do to start making those happen, even though it's kind of beyond the scope of what a normal NQF committee gets to do, so.

CO-CHAIR CHIN: But, again, this is what's special to our committee, it's not beyond the scope. It's the first time that any of the equity committees have been told go for it. So we're going for it.

CO-CHAIR PONCE: Sarah.

MEMBER SCHOLLE: So we've talked a little bit about the audience that we're speaking to. And we tend to frame it in what does CMS want and what can CMS do? But there are other audiences that we might want to be considerate of and think about what that means, particularly states, given their greater primacy in this new world.

But, also, I'm particularly interested in thinking about how to address individuals, and for many of these publicly reported measures what, what we're communicating. And that may be something where we want to highlight how our work is relevant to those different stakeholders or how it's not.

CO-CHAIR PONCE: Thanks, Sarah. Eduardo.

MEMBER SANCHEZ: I don't know if this is the right place or the right thing, but the presentation that came I think right after lunch was about, or maybe just lunch, was about the measures that exist and the degree to which they're being used. And Sarah did a presentation that also elucidated that, let us know that they're not being used.

But I talked to Sarah. And it sounded to me like the CMS data around race/ethnicity are not required, they're voluntary measures. And I just wonder if our recommendations, if we hadn't already thought about it, should include some statements about maybe moving from voluntary to not so voluntary. And what might be some other, some other bits of data that can and should be collected?

Because when I think about the opportunity -- and, again, in the conversation with Sarah we're talking Medicare as potentially a place where we could gather data; Medicaid; the degree to which exchanges continue, that's another place. And that can begin to set the stage for what others would and should be capturing because the degree to which it's Medicaid managed care plans that are done by the private and/or Medicare Advantage, that you again begin creating at least enough of a intervention into the way people do their business that they may just decide we ought to be doing this for all of our business.

That was one.

The second, and I wonder if there's an opportunity for us to include in there a recommendation for CMS to nudge, if that's the right political term or bureaucratic term, to nudge IRS to perhaps put a bit more teeth into what data is collected at a CHNA level so that we have a different way of getting at the community level data in addition to patient-specific gathered data.

CO-CHAIR PONCE: Great. Thank you.

The Medicare data looked like it was

doing better than commercial based on the --

MEMBER SANCHEZ: Yes.

CO-CHAIR PONCE: But the commercial was still, or race was still 70 percent unpopulated, but it was missing or not, which is I think the case from 10 years ago when we were on the committee, looked at data quality.

Nancy.

MEMBER GARRETT: Well, I also wonder, based on some of the discussion about our data scarcity about if there's a different way we can engage the private sector. So we talked about companies like Acxiom and, you know, some of the users we've had. And we had kind of a sidebar conversation over the break about credit card companies and companies like Experian that almost all providers work with. Some companies like that in their revenue cycle processes to try and understand risk, financial risk and target resources. And that's a great proxy for the kind of SES variables we're trying to get at.

And they're not really represented in

our group. And I just wonder if reaching out to them in a more systematic way would be helpful in these conversations.

CO-CHAIR PONCE: Great. Thank you.

Just a clarification to Christie. Isn't the Acxiom data, doesn't that include some of the financial data, and Experian?

MEMBER TEIGLAND: Yeah, it totally does. They have a whole module on financial aspects of what would an Experian collect to get your credit score. So do you pay your bills on time? You know, what are your financial buying habits and payment habits and so forth? Do you have credit cards? I mean there's a whole set on that in the Acxiom data, actually, as well as an income section, you know, social, you know, buying behaviors. There are many, many sections in that data.

MEMBER GARRETT: But one difference might be that a lot of providers are already working with the -- it's the revenue cycle --

CO-CHAIR PONCE: Right.

MEMBER GARRETT: -- the credit companies in the process, and so the data already exists in a sense out there. And so it just might be a different relationship to explore.

CO-CHAIR PONCE: Yes. Noted. Thank you.

Kevin.

MEMBER FISCELLA: Yes. I agree with your earlier comments. I do think regarding the whole issue of risk adjustment here and where to go, I do worry that until there is some sort of adjustment that there will be continued both angst on the part of hospitals and safety net providers that, one, they would be gamed and, two, I think it undermines the credibility of the measures.

Despite the empiric evidence I think there's a perception -- and it may not hold for all the measures, and there may be some, like you said, if you're 200, one that's way out of whack that you really could end up paying a whole lot of money.

And if by and large the variances is

relatively small, it probably is, the risk of sort of lowering the bar is probably relatively low. In other words, it plays on both sides. If you see big effects then, you know, in fact if you're worried that you may be in essence lowering the standards of care with that adjustment, that's a much bigger concern than if the effects are relatively modest.

But at the same time, I think we can't deal with that issue without the issue of active interventions to begin closing that gap and finding ways through innovative payments to begin, you know, perhaps going after some of these quality gaps directly. That would then begin to address those gaps and promote from our equity.

So I think that the conversation around ultimately where do we go with SES risk adjustment I think needs to be linked to, well, what else are you going to do on the other side to promote equity. Because, clearly, just adjusting for SES is not going to be a panacea in terms of resources for safety net hospitals. I think that's pretty clear and that's not going to happen.

Failing to do it, probably on the average, on the net average is going to hurt some, and probably some quite a bit. But if we really want to get resources to these hospitals in a way that incentivizes equity, then we need to do that in more direct ways. And I think that that's probably our next task, to really be brainstorming about that and thinking more deeply about how to do that.

CO-CHAIR PONCE: Thanks, Kevin.

Helen.

DR. BURSTIN: I'm just going to follow up on something Kevin said, another issue I want to make sure we don't lose sight of. So even if we think beyond adjustment and think about payment, there are different ways even around the measurement side I don't want to lose sight of. So, awhile back we talked about, for example, rather than paying not achieving a threshold, you pay for degree of improvement. You know, there are some strategies around measurement and payment that could still work best to close gaps and improve equity beyond the adjustment fees.

CO-CHAIR CHIN: Right. And we might look, it's one of the NAM reports, I think it may have been Report 3 or 4. There was a nice chapter around 8 or so that has like eight different ways of variations on, like, ways to pay. It goes through a nice schematic. It might be well to pull up this.

DR. BURSTIN: Yes.

CO-CHAIR PONCE: Philip.

MEMBER ALBERTI: Just also picking up on Kevin's point in terms of measurement to action. Right? So, we spend a lot of time thinking about not only internal structures and culture for equity, but also the kinds of partnerships in data collections and collaborations that are really necessary for safety nets in all hospitals to really do this work.

Part of me thinks -- and I don't know what this would look like or how we would operationalize it here -- that we should walk that walk as a committee and begin to think about the development of metrics in partnership with housing and transportation, education; right? Some of the solutions live there. We're going to suggest that institutions and communities and patients and families be measured in some way in these intersectional kind of ways that we should think that through with our partners that also have skin in this game.

CO-CHAIR PONCE: Thank you. Eduardo.

MEMBER SANCHEZ: I'm going to piggyback on that because a thought that I had a moment ago is, and I don't recall from the second report the degree to which, in the spirit of what Philip said, we've thought about the criminal justice system as the place where most mental illness care happens for most people in most states. And then the degree to which the work we do is going to capture that, capture the disparities. And think about both from a direct clinical intervention perspective on the one hand. And then policy solutions that are outside of the clinical realm, quite frankly, on the other hand we might think about that.

And that's gargantuan. And I don't think it's quite the same in any of the other realms. But in mental illness it is, it's, it's huge.

CO-CHAIR PONCE: Thank you. Kevin.

MEMBER FISCELLA: Yeah. Just a piggyback on Eduardo's comment on the criminal justice system. I think that may be an area where we could think about some equity measures, particularly in terms of exchange of information and in-reach for pre-release care coordination. I think is really, you know, probably if you're going to look at what's going to have the biggest bang for the buck in terms of improving the healthcare or health of jail and prison inmates, it's at that period before their, before their release.

In fact, New York State had a waiver -- I think it's been temporarily withdrawn -- for its

DSRIP program, amendment to the waiver, to have Medicaid, to allow Medicaid to cover the cost of that, of that in-reach that would provide for consultation as well as, you know, medications. So that then when the inmate was released they had an adequate supply of medication, not just, you know, a 5-day supply with the, you know, hope that they're somehow going to magically connect with a provider within that time.

So I think that thinking about how health plans, ACOs, measures there that might look at that pre-release care coordination between jails and prisons and the community could in fact be a type of equity-sensitive measure.

CO-CHAIR PONCE: Thanks, Kevin. Christie.

MEMBER TEIGLAND: Yeah, just one, one more quick comment on the medication adherence measures.

I mean one of the most predictive factors is alcohol, drug/substance abuse, and then mental health conditions like schizophrenia, major depression, bipolar. Those folks are much less likely to be adhering to their medications. They're very not adherent to their anti-psychotic medications, which then leads them not to be adherent to their diabetes and cholesterol medications.

Those measures aren't adjusted for those factors because they want them to be, you know, applicable across all types of plans. And so because there are Medicare Advantage plans that provide drug benefits, but then there are Medicare Advantage plans that just are Part D, drug benefit plan, they don't use any of the clinical factors to adjust those measures because they it wouldn't be fair, right, it wouldn't be a fair, you know, level playing field across the types of plans that provide the same services to the beneficiaries.

So, you know, that's another issue to think about is applicability of some of these adjustments, even though they're very appropriate. There's certainly a conceptual and empirical basis, but it's not practical in practice. And so, you know, I know they're trying to synchronize measures across all these levels and of payer types and systems and all the levels we talked about. Sometimes that's not easy to do. Right?

CO-CHAIR PONCE: Thank you. Nancy.

MEMBER GARRETT: And Christie's comment just reminded me that this, we did talk a little bit about data sharing and policy and legal barriers to that. And I just wonder if somebody on our committee might want to have a parking lot item, is there anything that we can do to make recommendations in that space?

And I'm thinking about data exchange between medical care providers and social services, as well as substance abuse, data sharing. You know, there's a lot of legal restrictions there that are a big barrier. I know people are working on that but can our committee do anything that will make recommendations?

CO-CHAIR PONCE: Thank you.

On the phone, Dave, any parking lot suggestions for us?

(No response.)

CO-CHAIR PONCE: Okay. And Susannah and Yolanda?

MEMBER BERNHEIM: No. I would just reflect that I heard a mix of things that might fall into the parking lot suggestions and of things that might fall under the category for principles or concepts that we thought were important to highlight in the report that we may want --

CO-CHAIR PONCE: Yes.

MEMBER BERNHEIM: -- to separate.

CO-CHAIR PONCE: Yeah, good point.

CO-CHAIR CHIN: I'm going to call Ignatius. He's been quiet, very quiet. And he's a font of knowledge.

CO-CHAIR PONCE: We'd like to open for public comment for those on the line, please.

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

Okay, we do have a public comment from

Jayne Chambers.

CO-CHAIR PONCE: Thank you. Go ahead, Jayne.

OPERATOR: Jayne, your line is open. If you've muted, please unmute.

MS. CHAMBERS: Hi. This is Jayne Chambers with the Federation of American Hospitals. I really appreciate the robust discussion that you've had this afternoon. I wasn't able to listen to yesterday's, but I was able to listen today. And I appreciate the thoughtfulness with which you are approaching these very difficult subjects.

I did think that the committee should be aware that the hospital community has written a letter to NQF that I think will be shared with you at some point soon that asks for an extension of the trial period, for the SES trial period. We think that it's important for us to clarify what the trial period was trying to do. We think that there may not have always been clear communication and the community may not necessarily have understood what they should be trying to do in terms of testing various models and bringing forward some ideas and proposals to consider how to go forward and in what cases you might want to test measures and how we should test them.

So just wanted the committee to be aware of that. And I look forward to continued discussions.

Thank you.

CO-CHAIR PONCE: Thanks, Jayne. And it just has been dispatched to us. Thank you.

MS. CHAMBERS: Thank you.

OPERATOR: Okay. At this time there are no public comments.

CO-CHAIR PONCE: Thank you. Any comments from those joining us?

(No response.)

CO-CHAIR PONCE: Okay. We'll turn it back to Erin.

MS. O'ROURKE: Great. Thank you so much.

So I'm actually going to turn it right

to Mauricio so he can cover the next steps and what to expect in the coming weeks.

MR. MENENDEZ: Hi, everyone. I won't keep you here any longer than we have to be.

So the PowerPoints and the materials from the meetings are available now on the committee's share point. We'll also be following up with the homework assignments that we talked about earlier, as well as a more built operation of the roadmap.

Next slide, please.

For the third -- yeah, the slide before that. Yes.

For the third disparities report it will include the scan for performance measures. And we'll also be searching for current or emerging evidence-based practices with respect to measurement of effective interventions to reduce -- with respect to measurement of effective interventions to reduce disparities.

We'll also include an updated conceptual framework, along with a the revised amazing concepts that the committee came up with.

Next slide, please.

And the final report, it will be a composite of the previous three reports. It will also include the committee's recommendations. And along with that we'll have the 30-day public comment period, along with the final report.

And turn it back over to Erin. Thanks.

MS. O'ROURKE: Okay. So just to maybe pull some of those pieces together. So the third report we'll be, again, working with you virtually to get your input before our June meeting. I believe that's due May 15th. Drew, correct me if I'm wrong.

DR. ANDERSON: Yes.

MS. O'ROURKE: Yes. Okay, so we will do some more virtual work. Perhaps we won't use Google Docs, given that no one likes it. And I had a feeling your team --

CO-CHAIR PONCE: No one likes it over 30.

(Laughter.)

MS. O'ROURKE: So we'll find maybe a better way to collaborate and get virtual input that is a little less frustrating.

We'll bring the findings of that report to you at the June meeting, in particular what we found for the environmental scans from measures, so that the committee can start to do some of the work to prioritize and help us identify the best possible set for measures.

We'll also spend quite a bit of time on, as Mauricio was saying, the policy levels and what we can do to get these measures in use, how we can really not just put together a set of measures and gaps but really put some teeth behind them and what other things we could do.

And then the third map we'll really be pulling those three threads together from the first, second and third report so that, hopefully, the whole picture of what the roadmap is and where we can go is clearer. So that one will come out after your second in-person meeting. It will include the findings of that, that meeting. And then we will bring you back together virtually, I believe in August, to review all the public comments and make any applicable updates. So.

CO-CHAIR CHIN: Question for Helen. Is there any idea about the communications plan for the final report yet?

DR. BURSTIN: No. Have some things to talk about with CMS.

MS. O'ROURKE: Yes.

I think with that -- Eduardo?

MEMBER SANCHEZ: Along those same lines, is there -- and maybe I missed it -- is there a formal, is there a plan for formally engaging and inviting input of other organizations? I think the American Heart Association would appreciate formally providing public comment. And there may be others.

I'm speaking out of ignorance.

MS. O'ROURKE: Oh. Actually, so just to -- we would love if all of you could share the draft report for comment with your organizations. And we do have a process to receive formal comments from outside organizations and respond to them. So I think if there's anyone in your network that would have insight who would like to share comments, we'd welcome that.

CO-CHAIR CHIN: And it dovetails with Philip's point about partisan collaborations, and so that if there is sort of a projected arc of this, then it may make sense strategically think about how to embed it at this stage, yes.

MEMBER SANCHEZ: So, and again just not to beat this to death, but as an example, in a couple of weeks the National Hispanic Medical Association is doing something. And I just wonder if around this particular document there aren't some organizations we want to make sure we put it in front of them and ask whether that's NMA or the Association of Black Cardiologists. There's many, many organizations out there. But they may have -- And then that's the provider organizations.

You've got hospital associations and others that may have not only a vested interest but really be keen on knowing this is happening and might provide some insight and appreciate the opportunity to have been asked. And, again, I figure you have that thought out. But I see other organizations that sometimes think they have that thought out, and two months later you hear that the report came out and there was public comment, and you know your organization was in no way informed.

MS. O'ROURKE: I think that's an interesting idea. Helen, I'm looking at you.

So I think we do have our formal public comment process. But perhaps we could brainstorm with you all over email who we can engage earlier and what groups want to be invited to the public comment. What we can do a little more upstream so that --

DR. BURSTIN: We've done that before. For example, we have a report that's out, just finished comment on diagnostics safety and quality. And used the Society to Improve Diagnosis in Medicine's 35 percent collaborative to say send this out on your listservs. And we've had a lot of comments. So, not surprising.

So any input from you on which places to post it for comment would be all in.

CO-CHAIR CHIN: Yes. And if we just don't want it to be a report on a shelf, this is the way to do it.

CO-CHAIR PONCE: And I'm wondering, I don't know how many people were on the public, you know, section online, but for the SDS and risk adjustment there seemed to be a really hefty of both consumer, provider groups.

DR. BURSTIN: Highest number ever. 650 comments on a single report. Still holds the record.

CO-CHAIR PONCE: Yeah. Well, I'm wondering if that's because the public doesn't know what our policy influence is? Or, you know.

DR. BURSTIN: It's highly variable, at least in my decade here. It's about how important the report is in the eye of various stakeholders. Is it sexy? Is it important? Is it timely.

And, secondly, I think it's how good a

job you do to let people know.

CO-CHAIR PONCE: Okay.

DR. BURSTIN: And, you know, with your help we could certainly fix the second one. I think the topic is obviously going to be, particularly with all the Medicaid discussions swirling around.

MEMBER SANCHEZ: I think that in the space of value-based health this is really, really important. Thank you, Erin.

MS. O'ROURKE: So, I think just on, so not perhaps immediate next steps, but we'll be coming back together June 14th and 15th. Similar process for travel as this time. You'll get a memo about a month in advance saying our department will let you know how to book everything.

I think, Drew, Tara, did I miss anything logistically?

DR. ANDERSON: Different hotel.

MS. O'ROURKE: Different hotel. Yes, apologies that that was a less-than-ideal situation.

But, yes, thank you so much all for coming and for all your wisdom and insight over the past two days. This has been phenomenal. We've got a lot to take back and to start to map out the roadmap to bring you something, hopefully, more concrete in June so that we can get that finalized and get it out to the world to Eduardo's point to hopefully give it some legs.

A special thank you to Marshall and Ninez for your moderating the past two days and for how much of your time you volunteered outside of the formal meeting to help us plan and get everything together. We really appreciate it.

CO-CHAIR CHIN: And I want to extend my thanks to the committee and to the staff, and Ninez and Helen and everyone here, that I think this is maybe my 15th to 20th NQF meeting. And this, this may have been one -- this is one of the top three anyway. One of the best ones. I mean just the input of everyone.

And, you know, talking about that on

the breaks, but we had no idea where this was going to go. But I think the discussion was great. And it really brought out the whole span of things. And people are really big thinkers and no one was narrow. So it was just great.

So thank you very much.

CO-CHAIR PONCE: Thanks. Safe travel.

MS. O'ROURKE: Yes. Thanks everyone. Safe travels and we'll see you in June. But you'll probably be hearing from Tara numerous times in the interim with homework.

(Whereupon, at 2:35 p.m., the meeting in the above-entitled matter was adjourned.)

CERTIFICATE

This is to certify that the foregoing transcript

In the matter of: Disparities Standing Committee

Before: NQF

Date: 03-28-17

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter