NATIONAL QUALITY FORUM

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DISPARITIES STANDING COMMITTEE

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WEDNESDAY
JUNE 14, 2017

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

PRESENT:

MARSHALL CHIN, MD, MPH, FACP, Co-Chair
NINEZ PONCE, MPP, PhD, Co-Chair
PHILIP ALBERTI, PhD, Association of American Medical Colleges
SUSANNAH BERNHEIM, MD, MHS, Yale New Haven Health System Center for Outcomes Research and Evaluation (CORE) *
MICHELLE CABRERA, SEIU California
JUAN EMILIO CARRILLO, MD, MPH, NewYork-Presbyterian, Weill Cornell Medical College
LISA COOPER, MD, MPH, FACP, Johns Hopkins University School of Medicine
RONALD COPELAND, MD, FACS, Kaiser Permanente
TRACI FERGUSON, MD, MBA, CPE, WellCare Health Plans, Inc.
KEVIN FISCELLA, MD, University of Rochester *
NANCY GARRETT, PhD, Hennepin County Medical Center
ROMANA HASNAIN-WYNIA, PhD, Denver Health
LISA IEZZONI, Harvard Medical School, Massachusetts General Hospital

DAVID NERENZ, PhD, Henry Ford Health System
ROBERT RAUNER, MD, MPH, FAAFP, Partnership for a Healthy Lincoln
EDUARDO SANCHEZ, MD, MPH, FAAFP, American Heart Association *
SARAH HUDSON SCHOLLE, MPH, DrPH, National Committee for Quality Assurance *
THOMAS SEQUIST, MD, MPH, Partners Healthcare System
CHRISTIE TEIGLAND, PhD, Avalere Health

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer
ANDREW ANDERSON, PhD, Senior Project Manager
MADISON JUNG, Project Analyst
MAURICIO MENENDEZ, MA, Project Analyst
ELISA MUNTHALI, MPH, Vice President of Quality Measurement
TARA MURPHY, MA, Project Manager
ERIN O'ROURKE, Senior Director

ALSO PRESENT:

IGNATIUS BAU, JD, Consultant

*** present by teleconference**

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

9:05 a.m.

CO-CHAIR CHIN: Okay. We're going to get started now, so welcome everyone, and Ninez and I would like to first thank you all for your service on the Committee. If you think about it, like about a year ago we started and a lot has happened and we've accomplished a lot, that I think when we first heard this charge of trying to do four reports in one year, that's pretty intimidating.

But we're well on our way. I think the first report describing disparities, the second on the effect of interventions, this current one on the conceptual model and the development of the equity domains, and then the last one in September will be the one on the policy recommendations.

So really we've come a long way, and I think we're in actually a very good space about being able to complete the work in an effective way. Special shout out to the NQF staff. You

think about it, like it's this magic that happens between these meetings or calls when we talk about general principles, and then these detailed, highly-referenced, well-written reports.

So I think we all know the great role that the staff is playing in terms of having such a great product in terms of these reports and recommendations. So thank you everyone on the team here. So let me turn over to Tara right now.

MS. MURPHY: Good morning, everyone. I'm Tara Murphy, project manager. I'm just going to take us through some quick housekeeping items before we dive in. First of all for those who don't remember, the restrooms are right across the elevator bank to the right. We'll take a break at noon and then another one at 3:15.

And if you need to for any reason leave the room, take a call, please do so right outside. If you need an office for a while, we're happy to provide a workspace for you.

Next slide. So we're going to start with introductions, just briefly since I know we did the full DOI last time we met. But if we could just go around the room for introductions.

We'll start with Nancy.

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

MEMBER RAUNER: Bob Rauner from Lincoln, Nebraska with One Health Nebraska ACO.

MEMBER COPELAND: Ron Copeland, Kaiser Permanente.

MEMBER CABRERA: Michelle Cabrera, with SEIU California.

MEMBER TEIGLAND: Christie Teigland with Avalere Health, sorry.

MEMBER IEZZONI: Lisa Iezzoni, Harvard Medical Center and the Mongan Institute Health Policy Center at the Mass General Hospital.

MEMBER SEQUIST: Tom Sequist at Partners Healthcare.

MEMBER CARRILLO: Emilio Carrillo,

Weill Cornell Medical Center.

MEMBER NERENZ: Dave Nerenz, Henry Ford Health System, Detroit.

MEMBER ALBERTI: Philip Alberti, the Association of American Medical Colleges.

MEMBER HASNAIN-WYNIA: Romana Hasnain-Wynia, Denver Health.

MR. BAU: Ignatius Bau. I'm serving as a consultant to the project.

CO-CHAIR PONCE: Ninez Ponce from UCLA Fielding School of Public Health, and I co-chair this with Marshall Chin.

MS. MURPHY: Thank you, and if there are any members of the Committee on the phone.

MEMBER BERNHEIM: Hi. Susannah Bernheim is here. Can you hear me?

MS. MURPHY: Yes, we can hear you. Thank you for joining us.

MEMBER SANCHEZ: Good morning. I'm Eduardo Sanchez. I'm calling in from Dallas, Texas.

MEMBER FERGUSON: Traci Ferguson,

WellCare Health Plan.

MEMBER SCHOLLE: Good morning. It's Sarah Scholle from NCQA.

CO-CHAIR CHIN: Sarah gets special commendation, because I think it's like 4:00 a.m. in Alaska right now. That's dedication. How about the rest of NQF's staff? Helen.

DR. BURSTIN: Good morning, hi everybody. Thanks again. Helen Burstin, Chief Scientific Officer, NQF.

MS. MUNTHALI: Good morning, Elisa Munthali, Acting Senior Vice President for Quality Measurement. Welcome back.

MS. O'ROURKE: Good morning, everyone. Erin O'Rourke, Senior Director with NQF.

DR. ANDERSON: Good morning. Drew Anderson, senior project manager.

MS. JUNG: Good morning. Madison Jung, project analyst.

MR. MENENDEZ: Hi everyone. Mauricio Menendez, project analyst.

CO-CHAIR CHIN: And before I turn it

back over to Tara for more of the overview, one thing I'd mention is that the timing of this overall Committee is just really, really good, that besides the NQF work, there's a lot of other work that's happening in CMS, the National Academy of Medicine, Department of Health and Human Services, ASPE. All align very well, and so we have the chance to have an impact.

As an example, yesterday at the National Academy of Medicine, they were having one of the panels that we'll talk a little bit more about actually later in the day, about the adjustment for social risk factors in performance measurement, and about six or eight of the people on the Committee were at that particular meeting.

But one of the general themes is that in some ways these issues sort of hang in the ether, but more clarity needs to be made both in terms of the social risk factor adjustment issue, as well as the other ways that performance measurement can be used to reduce disparities.

So I think it's really important that

we come up with a good third and fourth report, because it does have a chance to be particularly impactful, and I think others like later when we have a discussion about that meeting, we can talk a little more also. But again, it is a great opportunity and it's great timing for the overall Committee. So, Tara.

MS. MURPHY: Thank you. So I'll just quickly take us through our objectives for today and tomorrow. Today, we'll finalize the conceptual framework. We'll also identify gaps in measurement and identify priority measure concepts that will be follow-up on the pre-work that you all completed.

We'll continue our policy recommendation discussion from this afternoon into tomorrow morning, and then tomorrow afternoon we'll discuss the SES risk adjustment trial evaluation period.

This next portion, in this next brief portion, I will very quickly take us through a project overview, none of this will be new

information. Just a quick recap for those in the room and those on the phone, just kind of a broad overview of our project.

So as you're all very familiar by now, we're tasked with providing guidance on how measurement can be used to address disparities in the five selected condition areas.

Those conditions are cardiovascular disease, cancer, diabetes and chronic kidney disease, infant mortality and low birth weight, and mental illness. We look at these five conditions across the social risk factors identified in the 2016 National Academies report, Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors.

Those factors are race, ethnicity, gender, social relationship, socioeconomic status, disability, and residential and community context. Over the course of this task order, we'll complete three interim and one final report, which will include an environmental scan for measures, identify gaps in measurement,

develop a conceptual framework to guide performance measures.

These activities will culminate in a set of recommendations for measure development to assess efforts to reduce disparities in health and health care in the target conditions. To date, we have submitted all three interim reports, which include the conceptual framework, the final version of which will be included in the final report.

Next slide. As you can see on our project time line, following this meeting the project team will continue work on the final comprehensive report, which will include the recommendations made here over the next two days. The final report will build upon the three previous reports and present the Committee's final recommendations, and the draft will be posted for a 30-day public commenting period beginning in July.

The third report, which was just submitted to CMS yesterday, included an

environmental scan for measures as well as the conceptual framework that's been built over the course of the project to date.

As part of the third report, the NQF team conducted an environmental scan for measures that address disparities and effective interventions in the five condition areas. The team also reached out to the chairs and other key committee members of relevant NQF standing committees, to serve as key informants to our scan for measures.

Here you can see a tally of all the measures that the team found, by condition area and by domain. The team found 886 measures that address one of the five condition areas or cut across condition area to address disparities. The team tagged each measure to one of the domains identified by the Committee and described in the third report.

As you can see and as was discussed in the report, the majority of these measures were identified in the high quality care domain.

These measures were mainly clinical measures that addressed an effective intervention in one of the condition areas. The fewest measures were found in the partnerships and collaborations domain.

Here we have our final five domains of measurement. They are culture of equity, structure for equity, equitable access to care, equitable high quality care, and collaboration in partnerships. Each domain includes sub-domains which you can see on the screen and which are detailed in the third interim report. If there are no other -- no questions on this background information, I'll turn it over to Drew for the main event.

DR. ANDERSON: So we can also go back to that slide a little bit later, just so you can see the final list of domains and sub-domains, because we'll be spending a part of this next section discussing those in more detail and how they fit together.

So I just wanted to give a brief overview for the public and those online about

where we've come from in the measurement framework, and how it's developed to this point, and just to put this up on the slide, this is where we initially started looking at these risk factors that were identified by NAM.

And here is the original framework that we have been building over the life of the project, and I'll go over some of the updates that we've made since then. Obviously, we'll be making additional edits through this meeting and leading up to the final report, because this measurement framework will really encapsulate all of the Committee's --- at a high level, illustrate the Committee's recommendations.

So this really looked at it in four steps. So it was identifying disparities. We have a measurement development life cycle for health equity measures, and then it goes to incentivizing the reduction of disparities through measurement through several, or five here, policy recommendations that we'll be building out over the course of this meeting.

In our revised version of the framework, we've been getting more into the weeds as far as what each one of these steps mean. In the first step, we wanted to differentiate between stratifying measures to look for disparities and then also using -- selecting and using health equity measures.

So this first step is looking at disparities by stratifying disparity-sensitive measures, and we included in the meeting materials a previous report that NQF has done looking at communication-sensitive or disparity-sensitive measures. We came up with a -- a previous committee came up with a protocol in 2012.

So we have adapted it to this project, looking a little bit more broadly. So the protocol is made up of these two tiers. The first tier is looking at the prevalence of the disparity, and then the actual quality gap, how wide is the gap between relative to the group with social risk factors, and then what impact

does this -- does the disparity have on the group we're looking at in particular.

In the second tier, we look at whether or not it's a communication-sensitive measure. So is it associated with language barriers? Is it associated with care with a high level of discretion?

So this was really care that there might not be a standard or there might be multiple options. There were some examples about shared decision-making here, and then the last piece was the social determinant-dependent measures.

So this follows nicely with the flow of the project so far. So how we've been having these discussions about how to select health equity measures is to -- we need to have them tied to interventions that are known to reduce disparities or evidence. So Step 2 of the framework now will look at, you know, what research, what research is -- what evidence is available to suggest that certain interventions

reduce disparities and what measures do we have to ensure that stakeholders are employing those effective interventions.

And then from the first or the second interim report, we identified a number of interventions that cut across all of the condition areas that we looked at, and they were more general looking at patient education, lifestyle modification, culturally-tailored programs. We saw a lot of examples of community-based participatory research, bringing in community members to be a part of developing interventions.

We also pulled back a number of recommendations from AHRQ, IHI, RWJF and then also some systematic reviews of intervention just to provide examples of the types of interventions that are out there that could be measured. And then we -- a part of the second step of the framework, we adopted an expanded version of the SEM model to more applied to health care settings and stakeholders, and came up with this

recommendation that interventions need to be applied at all levels of the U.S. health care system.

So we're looking at the policy level, the organization level, the community level, and provider level. Okay. And so this brings us to Step 3, which is where we came up with the -- or the Committee came up with the priority domains of measurements.

And so these are intended to be measures, health equity measures that are tied to those effective interventions, and we have this figure here that is meant to illustrate the relationship between the domains.

So we have the culture of equity supporting the structure for equity, then structure for equity making more equitable access to care once -- and then leading to this equitable high quality care, hopefully to then achieve health equity, but recognizing that collaboration and partnerships between the health care system and non-health care sectors are

necessary to achieve goals within each one of these domains.

And then lastly, Step 4 is to incentivize the reduction of disparities through measurements. So these are really the policy recommendations, and these are the five where we landed since the beginning of the project.

So the first is incorporating equity measures into payment and reporting programs, aligning equity measures across pairs, incentivizing preventative care, primary care and addressing social determinants of health, assisting safety net organizations through vulnerable by serving -- assisting safety net organizations serving vulnerable populations, and conducting and funding demonstration projects to test payment and delivery system interventions to reduce disparities.

So we will be talking about these and building on these throughout this morning and into the afternoon.

Here is just a revised step-wise

version of the framework. It is just an illustration of the steps that I just went over, but this is just a draft and we'll continue to make sure that it illustrates all the concepts that we want it to, or conveys the message that we want it to convey for the final report. But it's just kind of a high level overview. And we can come back to this.

So as I said before I started giving this overview, we wanted to go over a couple of discussion questions related to the domains, just to get on the same page.

These discussion questions are really to figure out what the intended use is for these domains, and then how they fit together. This question here about are they considered a set or can stakeholders pick and choose from them based on their priorities.

So I'll turn it over to Ninez and Marshall and walk us through the discussion. Thanks.

CO-CHAIR PONCE: Okay, thanks Drew.

Nancy Garrett?

MEMBER GARRETT: So Drew, I just was a little confused about the disparity-sensitive measure and the materials that we got this report from 2012. Can you just give us a little more context of how this fits together with the work of this Committee? Is this previous work that was done?

DR. ANDERSON: Right. So it was previous work, and that's actually a discussion question that should be on the slide. We want to see how we can adapt that criteria or some criteria like it to advise stakeholders, like how, what -- what are the priority measures for stratification, essentially. So this was just a previous project that was done in this area specifically focusing on an area of culturally competent care.

But obviously we're looking more broadly than just cultural competence. So we wanted to see if there was ways for us to adapt that criteria to this current work, to provide

more guidance on stratification in that initial step.

MEMBER GARRETT: So the disparity-sensitive categorization scheme might be something we discuss today, and whether we want to continue it?

DR. ANDERSON: Right.

MEMBER GARRETT: Okay, that's helpful.

CO-CHAIR PONCE: Bob and then Juan, and then Romana.

MEMBER RAUNER: As kind of another kind of contextual question like what are we going to with our fourth report, the ASPE and NAM reports I think are going more in this direction, where they're adding more specification recommendations on what should be done.

The one thing, you know, when you have this list of measures in the back, most of them are hospital and/or new measures, but there's almost nothing that's from either the Medicare Shared Savings Program or the EDS measures that federally qualified health centers use. And I

think we need to -- my understanding of our charge is we're supposed to focus on the things that are in value-based purchasing.

Those go back to those measures actually, and I think like for cancer, for example, it's breast, colon, and cervical cancer, HPV vaccination. These are things that FQHCs, the Medicare Shared Savings Program are working on right now and that's what their incentives are, either going to hurt or harm them. Is the fourth report going to start into that area, or is that the next committee or something like that?

CO-CHAIR CHIN: I'll take a first crack at it. I think a lot of what we're doing still is fairly high level in terms of like the big general principles. Like for example, the conceptual framework, the equity domains. But when we talk about like the policy recommendations/use of measures part, I guess this can be probably fairly high level also as opposed to really specific.

Because there's such a void right now in the overall field, and so much through these general principles need to get out first. But I think that if we do that well, then the next step for like CMS would be like being more specific for specific programs, it will be a great help for them.

CO-CHAIR PONCE: And this is Ninez. My understanding too is that so these five domains, and perhaps we can go back to the target with the -- so but this one, I think this gets at the domains, because it's the culture of equity, structure for equity, equitable access to care, equitable high quality care, and then cross-cutting is collaborations and partnerships, right, with the target of achievement of health equity.

This came up from all the work we've done in the last meeting, when we all had -- we broke up into small groups and then we went out and got to this point. And then that framework was put with the work that NQF did on what

measures are available.

So it eliminated where the gaps are, and that's the chart where you have the -- we can go back there, so that we can walk the Committee to refresh.

(Pause.)

CO-CHAIR PONCE: So that got us to -- so the measures that they reviewed got us to this chart, put in the context of the five domains that this committee arrived at. And so from this we see that the partnerships and collaborations is where we need some more work, which is why we think called out a pre-work for those folks here and this structure, actually the structure for equity did pretty well.

But then access to care at 52 and culture of equity. So that's kind of the process of the work that you've done to where we're at now. But I do echo your concern, Bob, that then it's what are we going to do with these? We identified gaps. This is what Marshall actually in the back would always keep saying, what are we

going to do with this and how we can operationalize this.

But we have measures already. But for this exercise, it's what are the domains that this Committee has developed from all of our meetings together, and then incorporating the work that we've been doing for CMS?

MEMBER RAUNER: So like for example, because this is NAM's report, where they actually call out -- they use the example of the hospital readmission penalty. Will we have anything like that? Like for example, colorectal cancer screening. We know there's significant disparities, geographic, income-related.

You know, David's article last time pretty much highlighted. It has huge effects. Are we going to use that as examples or is the step forward going to be mostly conceptual?

MS. O'ROURKE: So I think the next session would be great, when we can call out some specific examples, particularly when you look at this chart how many measures there currently are

in this high quality care domain.

I think if there are particular measures that we could call out and say these are ones that need focusing on, and then when we get to some of the policy focus conversations in the afternoon of those concrete examples of specific programs or payment incentives that the Committee wants to highlight, I think particularly around where we have the five disease areas that we've been focusing on.

So I think colon cancer can be a great example to build out through our conversations today.

CO-CHAIR CHIN: Over the next two days Bob, some of us might think of it as three different parts of the meeting, we end the meeting with a discussion of the trial period for SES demographic risk factor adjustment. So that's just one bucket of things. A second bucket would be this morning, so much we tie together -- where we ended up at the last meeting.

You remember everyone was in the corner there. I remember Ignatius was on the white board and we had this long list of 25 different domains, and it was trying to collapse it down to a reasonable number. So that would be a five up there, as well as hopefully the five having some type of logic to it in terms of how they fit together.

So that's part of what you're going to be discussing, and then Evan's point about well, what you have are these measures. Then what does that means in terms of how they're used? Is there a logic or not, or if there is no logic to it, do we need to improve it, that type of thing. That's a second bucket.

The third bucket is this afternoon, where it's like the well, now that you have these measures, well what are the different leverage can you use then in terms of measurement to reduce disparities? The social risk factor adjustment is one, but only one of the different levers.

One of the interesting things about like this meeting yesterday was that the topic was social risk factor adjustment. But I would say at least half the discussion was really on the other stuff, because people realized that social risk factor adjustment is a piece of the puzzle, but it actually may not be the most powerful lever. And so it also has to sort of fit together so --

DR. BURSTIN: Just one quick thing. Specifically, if you look at the high quality care listing there, that's where the majority of measures are. The way we've used the disparity-sensitive measurement approach in the past is as a way to at least identify which measures should actually be stratified.

So I think some of it is bringing this back to you. Does that schema make sense? So even if we don't use it to identify every measure today Bob, I think the question would be how do we build this into our process going forward? So the HIV Committee a while back specifically

identified viral load suppression as a disparity-sensitive measure.

But we felt like it was time to refresh this approach with your guidance, and then build it into our work going forward.

CO-CHAIR PONCE: Thank you. I think it is very helpful. Juan, and then Romana and then Michelle.

MEMBER CARRILLO: I know it's Juan, but it really is Emilio.

CO-CHAIR PONCE: Oh Emilio, sorry.

MEMBER CARRILLO: Yes, okay. First, I think that the team did a great job collecting, integrating and just distilling the discussions that we had at the last meeting. The second thing I want to just point out is that the 2012 report, the disparity-sensitive measures were looking at the 2011 NQF portfolio of measures. So that was where the -- this particular discrimination was focused on.

And the one thing that's missing here is the issue of structural racism, which is

something that's been addressed now. I mean right now, NIMHD had a whole meeting on that. People are writing about it, and it's just something that we should consider.

CO-CHAIR PONCE: Thank you. Romana.

MS. MURPHY: So in terms of the topic of stratification that we're going to address, I'm just wondering, you know, and Dave's here, in terms of the previous committee, our risk adjustment and the guidance on stratification versus risk adjustment.

I'm curious how we're going to connect that. I mean there was very explicit guidance and it gets back to Marshall's question of how are these measures going to be used and operationalized. I think the stratification issue is a big one in that in terms of use. So I was just wondering if you could provide some guidance around the previous work, the guidance from that work.

I know there were a lot of questions and, you know, I'll just say some controversy

about stratification versus risk adjustment. So as we visit risk or stratification, how are we going to make that connection and how are we going to focus on operationalizing and use?

CO-CHAIR CHIN: So that's a great question. We'll devote the whole afternoon to those types of issues. In some ways like the Committee has off and on talked about a variety of policy recommendations, but we haven't really systematically marched through the key issues.

So like we looked at the agenda for this afternoon. It was the Committee's, well the staff's attempt to basically come up with like some guidance questions to help guide that discussion. But that's a critical one that you're asking so please speak up when we get to that.

CO-CHAIR PONCE: Susannah, on the phone and then Michelle. And then Lisa.

MEMBER BERNHEIM: Hi thanks. Just a quick question about the category of high quality care, because there are so many measures there

and I think I was expecting that that was mostly going to be examples where stratified results are being used to highlight disparities, to sort of incentivize decreasing disparities.

But when I look at our domain for that, I see that we include, I think -- so I'm trying to be clear about what we're churning as a measure here, because I'm a little concerned that we're going to say that this domain is fine, whereas in my opinion we're missing a lot in this domain.

So I think that if I'm reading this right, we want a lot of things in this domain, which is sort of anything that looks at family and caregiver experiences of care, communications, shared decision-making, support self-care. They're factors in improving equity, but they're not necessarily sort of directly measuring whether there is equity in high quality care.

In that second bucket within equitable high quality care speaks to stratified measures,

and there's a couple of examples. Then there's also team-based care, care managers. So if the Committee can just or the NQF staff can just confirm that all of this stuff is in here, and so that we could have zero stratified measures. But if we have things that are looking at patient experience and team-based care, they're going to count in these categories, it that right?

MS. O'ROURKE: Yes, that's correct. Unfortunately, we didn't always have information about how a measure is used and reported, so Susannah is correct. It might not necessarily have a stratified result out there.

MEMBER BERNHEIM: So we may want to think when we're talking about gaps, about whether we want to look a little at the sub-domains, because if we make it look like one domain we've got it nailed, we may be missing key gaps. So I think it's just worth considering some of the sub-domain groups.

CO-CHAIR PONCE: That's a good point. Thank you, Susannah. Michelle, and then Lisa.

MEMBER CABRERA: Thanks. You know, I just want to kind of build on Bob's point earlier and say that for me, I look at our charge as trying to help guide a process where we're identifying disparities, and through quality measurement, right.

So we help -- in the macro sense, we are looking for where the -- assisting people to find where disparities exist, and then we're also -- I think one of the responsibilities for NQF should be to hold itself accountable for the impact of how measures are developed and then applied to either, you know, helping to close the gap on disparities or potentially even harming parts of, you know, these impacted communities.

So I think that's the one piece that I feel like it's the big picture piece, and I'm not sure we're quite getting there. I see a lot of contentious debate within some of the measure developer conversations, and I'll admit I don't understand everything that's going on there.

But if -- you know, there's a lot --

I do understand the tension. I understand the back and forth, and I think the anxiety is about people are concerned that the measures themselves are a tool that when applied, sort of without regard to the impact, can actually themselves be driving further distance in disparities.

That's the piece I think we have to -- we do have to get in the weeds, but we also have to pull out and say wait, are we actually achieving this goal of understanding the impact the measures themselves have, and part of the trouble that I see with that is that we are in this interesting moment of a change in how people are thinking about all of this, and while there may be certainly it seems like buy-in that stratification is fine, that it doesn't mess with our tools, so to speak, there is a lot more concern around well, then what happens once you start messing within my tool, right?

So I just think that we need to struggle a little bit with that while we're having these other conversations.

CO-CHAIR CHIN: Thanks for that comment Michelle, it's a really good comment. The great opportunity on this Committee is that this is the first of the NQF disparities committees that was charged with coming up with the broader road map.

In fact as far as I know, all the priority disparities efforts were forbidden from actually sort of crossing that line to talk about exactly what you're addressing, essentially the use of the measures, whether it's like the negative unintended consequences, or better yet how do you use the measures to correct or reduce disparities.

That's this afternoon's discussion. So please be an active participant this afternoon, when this is the chance.

CO-CHAIR PONCE: Lisa.

MEMBER COOPER: So first of all, I think the staff have done a wonderful job on putting together this report, and also I just want to say it's good to be back. I've been away

for a while from the group. So I guess what I'm struggling with a little bit is that I am trying to understand whether the measures we select have to have -- not only have some sort of demonstrated disparity that exists in those measures, or whether we actually are also requiring there to be proven interventions that address that gap.

So I guess the reason I'm bringing that up is because I really do think the partnership and collaborations measures are very important. However, I don't know that we have the evidence that those measures actually -- whether there are actually interventions that exist that document that those measures have an impact on disparities.

So I would like us to recommend them and I think they're very important to be developed, but I'm just wondering what criteria we're using for including the measure. Like how rigorous does the evidence need to be? Do we just need to say that it's a measure where

there's been a documented disparity, or does there definitely need to be some sort of evidence-based intervention whereby if there's a disparity identified that there's something that people can do to address it?

CO-CHAIR PONCE: So Emilio, I'm going to go to Helen, because maybe she'll address this.

DR. BURSTIN: It's a great question Lisa, and welcome back. I think you got to the heart of the matter. I think that's something we want you to help us with. I mean one of the things we've put in our prioritization criteria for measures, not that all measures need to be, but there's a preference for measures that are improvable and actionable.

That doesn't mean in this particular area I think where the evidence around what is in fact improvable and actionable is often more difficult. It doesn't have to be exclusively what you rely on, but we might actually want to be able to separate those out and say these may

be really -- these are incredibly important, perhaps more aspirational because there isn't clear guidance on what could be actionable. But I think this is a great question for the Committee.

CO-CHAIR CHIN: And let me reflect a little bit back on the last meeting, and maybe the Committee can tell me if you think I'm interpreting the Committee accurately or not. When we had a brainstorming session at the end about what these example domains for equity, some of that was evidence-based, as Lisa was saying.

I think some of that was based upon people's experiences of what does it take to reduce disparities. So for example, all the culture of equity things, that we know that's -- well, we know from -- we know from randomized control trials, but we know from the people who do a lot of work with the different organizations, that unless there's buy-in from senior management well you can only go so far, on this culture of equity.

I guess from the evidence base for like an RCTF community health worker, but if the -- and my interpretation was if the Committee's -- if the goal is to try to improve equity, well somehow we want to be able to measure and reward institutions that are further along in terms of prioritized equity, for example. So as Helen said, I mean you look at those five different domains and the different sub-domains, there really is a spectrum of different issues.

Another example would be like Emilio's point about the structural racism. There was a great discussion about that the last meeting. Well, I don't know any studies that have looked at that particular issue in particular, but then you could extrapolate things like well, if your health care system isn't designed to take certain diverse populations, is that sort of in some ways a sequela of structural racism or what-not?

So it gets back to Bob's point about like well, all these different domains. So I think the best -- in some ways the purpose for

this morning to figure out well yeah, in this sort of thorny area where we're using some combination of evidence and expert judgment essentially, what do we do?

I mean look at the NAM reports. Like the second one was the one about their best practices for caring for socially at risk populations. They admitted up front that well, you know, they're going to do a combination of literature review and expert judgment. It's just the nature of the question is hard.

So I guess so similarly, we have to sort of struggle with this this morning about where do we fall.

CO-CHAIR PONCE: Emilio, you had --

MEMBER CARRILLO: Yes. I just wanted to piggyback on Lisa's point precisely, where she said the actionable is really critical it's not a current consideration when we look at measures in the NQF.

But in this case, I think it should be added, and actually about a year ago we

circulated a paper on a framework for looking at the health care access barriers and measuring them, which includes the actionable component as one of the key ingredients. I think we can probably send that around again if possible.

CO-CHAIR PONCE: I'm sorry, Bob.

MEMBER RAUNER: I just want to make a really, really concrete example that addresses this. For example, I made a $4.7 million gamble last week, by bringing in our two safety net clinics and their ACO. Blue Cross/Blue Shield has seven measures, their clinical measures they're going to judge us on. Brought in the safety net clinics because they need the funding because they're struggling just like your safety net group is for the same reasons.

Two of those seven are the very measures that in David's article shows that there are significant differences. The way the Blue Cross/Blue Shield is doing it, our quality measures are all or nothing, and if we miss a certain benchmark we get zero savings actually.

If we achieve savings, we lose it all because our quality isn't good enough.

And so, you know, the two safety net clinics are only about eight percent of total patient population, but if it's that close, bringing them in could cost us $4.7 million next year. And so I would argue that we have an ethical ACO and probably we had an ethical duty to bring them in. But if we were purely financially motivated, we would have not brought them in.

So this is very real time, and I think there are interventions out there that show that if you do the care coordination reminder systems, you can improve your cancer screening. So the interventions are there, but we're already in a situation where measurement is harming safety net clinics. So I think that's -- I think that's what -- obviously that's why I'm here.

I think we need to get to the point where Medicare doesn't do this or Blue Cross/Blue Shield doesn't do this. I think that's a real

concrete example and kind of a gut check for everybody that -- get all the models. But the rest, when push comes to shove I got to hire care coordinators. I want to bring in the safety net clinics and I don't want to exclude them from all this.

I think a lot of federal programs right now are excluding safety net clinics or the rural health centers, FQHCs, partly because measurement isn't used -- because we're not adjusting for disparities. So I think that's kind of a good gut check to frame the context a little bit.

CO-CHAIR PONCE: Thanks, Philip.

MEMBER ALBERTI: Just a potential opportunity as you think about this balance between existing interventions and evidence and aspirations.

I wonder if this is a chance for us to propose kind of based on where we see the gaps, a formal kind of research agenda to go forward, to say here are the really salient research

questions. Here's what we need to know to move this conversation forward, and I think this could be really an opportune time to put something out like that.

CO-CHAIR PONCE: Okay, that's noted. Michelle.

MEMBER CABRERA: I don't mean to belabor this, but I do think -- I mean just as we're having this conversation about the various five domains, what I want us to be mindful of and try to avoid is again ghettozing the disparities and equity conversation, right.

You know, I feel like prior to this current moment, it was ghettoized in public health, and it was like public health does all this aggregate stuff and it lives way over there, and it's not connected to any of this. I want us to be mindful as we're doing this that people who are using NQF measures don't have the ability to come and say well, those people are working on equity and they apply these things, and I can just ignore it.

I mean I think how do we make it so that it's really not avoidable in how you're thinking about and applying measures? It should be part of our charge, giving guidance around that.

CO-CHAIR PONCE: Thanks, Michelle. Well, I've heard a lot of opportunity, as Phil said, to enhance NQF's road map and framework. So even Emilio your comment on structural racism, I think the structure for equity bucket could be enhanced to reflect the structural racism, and Bob what you noted about investing in safety net clinics, that could also be another quality measure.

So I think all of these -- so we want to hear your frustrations, because this is the forum for this opportunity to codify it in a way to guide NQF moving forward.

Well, there were a couple of questions which I just wanted some clarification from Erin. The second question is how do they relate to existing measurement domains.

MS. O'ROURKE: Sure. So this one's actually a point of clarification that Tara asked, is how does the Committee see these domains relating to things like the domains of quality, and I think Michelle maybe this touches on your point of how we need to keep these connected, and this is not a separate framework that other people are working on.

But how does this relate to some of the other ways we've defined concepts like quality, and does that help elaborate?

CO-CHAIR CHIN: I'll give a first interpretation. So like when Susannah mentioned on the phone call that, so some of it is you take some of the existing measures and you just stratify. So some of them are just existing domains that NQF or IOM or others used in the past and stratify.

But I think the thing that's different about like the five domains that the Committee has come up with, it also talks about the process. This applies to the process of change

also. So things like if you look at -- it's also the order of it also. I mean like that concentric circle, sociological model, where you have the culture of equity, you got to have the structures in place, you've got to have access to key areas.

You've got to have everything involved with high quality care and then the partnerships bring it all around. So in some ways it's sort of like -- it's almost like your classic Donabedian structure and process outcome, mixed with dynamic quality improvement in some ways. So to me, that's what is similar and different about this existing CMS ways of thinking about it.

CO-CHAIR PONCE: So Kevin.

MEMBER FISCELLA: Hi, this is just a broader, a broader question of, you know, one of the challenges as we think about stratification and sub-groups and measures is the proliferation of measures and measurement burden. I guess my first, you know, question in my mind is how to

handle that and minimize, minimize the proliferation of measures and the pushback that comes from that, as well as the more measures you have, the less likely there's going to be focus.

I guess related to that is the movement towards fewer process measures and more outcome measures that really get at equity, and how we as a committee really think about the tension there between equitable outcome measures and equitable process measures, and where that balance is going to fall and where the opportunities are to leverage, to leverage real change.

CO-CHAIR PONCE: Thanks Kevin, and I know David has commented on this, on process versus outcome yesterday at the NAM, and I wondered if you had any comments on this.

MEMBER NERENZ: Well, the comment I made yesterday was pretty straightforward. Obviously, there's a distinction and everybody knows what that distinction is. I think as we've had a number of discussions in the predecessor

committee and elsewhere.

We observed that organizations, particularly hospitals and clinics, find it easier to reduce disparities in process than they do in outcome. They find it easier, others do. The literature's been solid on this forever. You take diabetes, for example. It's not that hard to get rid of the disparity.

It's really, really hard to get rid of the disparity in hemoglobin A1c control. So that was my point. I see people nodding. I'm certainly not the first one to make that observation. But then how we use that here, I think, does take us to -- into some interesting directions. I think I would consider both of those broad sets to be legitimately sort of disparity-sensitive measures.

But I think as we roll them out into programs for accountability for organizations, that I think is where you start thinking about that distinction. Do you penalize an organization for failing to reduce a disparity

that nobody can get rid of? I tend to lean no, but others have different views, and but at the same time as Kevin points out, there's sort of a large shift among those talking about quality measures to move from process to outcome.

Process measures have their own downsides. I think in the end, you just have to end up with some kind of thoughtful balance as you populate any particular program. But I guess I'm also leaning to Marshall's point, that we're not at this day around this table sort of specifically populating measures for specific accountability programs.

I think we're left with sort of, you know, looking at the big picture and saying that, you know, within these domains, particularly the quality domain, there are and there will be process and outcome measures and then what we write about them we probably can make these comments. Process measures typically are within a provider's control, more -- it makes more sense to hold them accountable, particularly for things

that they directly hands on control.

So I mean there's phrasing that we can do. But I'm not sure how much farther we can go. I wouldn't take one group out or take the different group out. They both have their place.

CO-CHAIR PONCE: Thanks, Dave. Kevin, did you have any follow-up comments?

MEMBER FISCELLA: Yeah. I guess my only follow-up comment would be I think that using incentives perhaps on the -- on the outcome end and really beginning to learn from that experience in terms of essentially rewarding improvements in equity and outcomes and what can we learn about how that works.

I mean I think given the lack of evidence, particularly at the higher levels here as others have pointed out, I think this is really going to have to be a continuous learning process, where we learn from our experience and learn what works. You know, I mean I share David's concern about penalizing for outcomes where you need multiple partners.

On the other hand, I think potentially using incentives may be able to get at some of the community collaborations that, you know, Lisa was mentioning, because in the end we want community collaborations that are going to make a difference, not just on paper.

CO-CHAIR PONCE: Thank you. That's a good queue, because Lisa is up next.

MEMBER COOPER: I was just going to say that actually I agree with both Kevin and David, the comments about the balance between process and outcome measures. I think that's important that we consider both, and I just wanted to say that I really agree with what Kevin said about us being selective about the measures that we recommend.

I think that there's a potential that we could recommend a whole lot of measures, and I can tell you in my current role that I don't know why, but there's a huge amount of pushback to doing anything new, and so -- and I don't even know how much more work it is to stratify like an

additional measure. But just the idea that there's something different to do and their sort of questionable ability to act upon it.

I think it behooves us to really be very selective about the measure as a process and outcome measures we choose within each domain, that you know, realizing that there are lots of them that are available that people can do, and that they wouldn't be penalized for doing other things.

But that there should be a core set of really select measures that we are strongly recommending that everyone include, because otherwise it's going to really just get lost.

CO-CHAIR PONCE: Thanks, Lisa. I think that's what the road map will help with that. So Ignatius and then just do the roll on the queue. Ignatius, then Ron, then Susannah on the phone, then Emilio, then Lisa Iezzoni. Ignatius.

MR. BAU: So I want to really go back a couple of comments. Marshall posed this

question or made the observation that part of what this framework is trying to do is really cover the entire spectrum of issues that need to be addressed from something as basic as the structure and nature of the actual organization, all the way to are we actually influencing outcomes and improving outcomes for disparities populations.

I think a lot of times in the equity and disparities conversation we get hung up on both either end of that spectrum, that we really focus on issues like leadership or buy-in and then we don't get to outcomes, or we focus only on specific outcomes like how are your cancer screening rates, and we're not addressing those upstream structural, organizational issues.

So I think part of the challenge in the final paper will be out of this framework, what is most important to begin with, that obviously ideally you would want to do it all, but what is important, and to Bob's comment about sort of the inclusion of the safety net. So if

we elevated a measure like language concordance between providers and patients, that would actually give credit to the safety net.

If that were one of those things that you were incentivizing, as opposed to just colorectal cancer screening. So again, I think this framework gives us that opportunity to say can we give credit to particular organizations, in a way that again historically we haven't, but gets at what we believe will ultimately move us towards equity.

CO-CHAIR PONCE: Thank you, and I had a side conversation with Helen and she said we can influence the selection of the measures. So this is what this group will do. So I have Ron next, and then Susannah, Emilio, Lisa and Sarah. You're on the queue too.

MEMBER COPELAND: Yeah. I would just echo Ignatius' last comments about two of Lisa's points I'd want to make about this balancing issue between process and outcomes. First of all, I think we just need to be clear of the

diversity of systems, based on scale, capacity and so forth that constitute the community care delivery system.

And so it's clearly a scenario where one size is not going to fit all. So I think we just need to be clear about what is that core that's relevant to everybody, and how much choice or not is part of the recommendation that we ultimately would deliver, because aligning people's willingness and capacity to adopt versus not is going to be how stringent those approaches are versus how much flexibility there is without disrespecting the core things that we know are essential to achieve the equity outcomes.

And then the other thing I would just say in terms of a lesson from the field, at least from a lot of systems that have already started down the path of tying incentives to this work, it is not a binary orientation of do we incent process or do we incent outcomes.

Most of it's done in a stage way. The first incentives to encourage strong the adoption

of whatever the core practices and principles are is around process. Are you adopting the processes? Are you measuring those? Are they in place? Are you studying your outcomes and what are the trends showing?

When people have done that for some defined period and gained their confidence in the data, in the outcomes and get familiar with the processes, and there's been a cultural shift, then there's the opportunity to say that would move from Stage 1 to Stage 2. Now the incentives are disproportionate.

Now they're going to be focused on outcomes, because the data shows the processes are in place. They've been adopted. You're tracking those well, and if we believe that these core things really -- you've done it at a high level will result in decreasing disparities, now we're all comfortable going for the outcomes.

So there's ways to accommodate both approaches doing it in a stage way rather than the debate of it all has to be on a process or it

all has to be on outcomes from the very beginning, because there is an adoption period of the processes and that's what you want to incentivize first, because if those aren't achieved, then there's no hope to get the outcomes.

CO-CHAIR CHIN: While you have the floor there Ron, so if you look at like the current five domains, the culture, the structure, the access, the quality and then the partnerships, from what you just said, how does that translate to then like the current five domains the Committee's come up with and how they might be used?

MEMBER COPELAND: Well, I think that's an important framework. I like the continuity of them. I think there's not any big buckets missing, if you will, accommodating all five of those domains. I think those are the right domains, particularly in organizations around the notion of culture and the elements that we're trying to populate those with, all the way

progressing to outcomes.

So I see them as kind of the right linked sequence and all being relative contributors. I almost think of them as a maturity model, that it's hard to -- it's hard to advance some of the infrastructure, for example, if you don't have the culture and orientation around why it's important, how it's tied to quality improvement, carrying out your organizational missing, whatever the case might be.

So I think at first pass and to anchor a lot of the measurements or the core measurements that we end up with, I think it's a reasonable framework to start the conversation with.

CO-CHAIR PONCE: Sorry, I keep putting you on the hook Ron. Since you're touching on the third question, so you said they were linked. So you think they should be considered as a set or can stakeholders pick and choose from them?

MEMBER COPELAND: Well, I think what

stakeholders will pick and choose, most would probably start with a self-assessment on where are we on the journey with those five domains? Do we have anything going on in any of those domains at all, and if not then, you know, what's our -- or what is our map at an organizational level to move in that space?

But again, because of the fragmentation and diversity of where people are starting the journey, I think they may pick and choose where they start. But I think if we believe to actually get to the outcome of demonstration of achieving equity, all those are essentially core steps that I think they come as a bundle, for lack of a better term.

Then it's kind of where you start the process, but recognizing that bundle has to be achieved in real time, and simultaneously to have the best shot at achieving the outcome.

CO-CHAIR CHIN: I mean you've raised another -- I mean you're sort of on a roll here Ron. But you sort of raised the issue of like

well, are these like five domains to be used more from a quality improvement self-assessment purpose, versus on the other extreme accountability?

MEMBER COPELAND: I think it's both. I think it's a way of -- if that's the accountability step, the first thing I'd want to do is where do I stand on that. So it starts with a self-assessment of where you are, based on the metrics or in those areas the framework to give some thought to. I don't think we can ever get so precise that it will be all-encompassing.

But I think the most important thing is people have a framework that's got some evidence base to it. They start the journey, and they're committed to continuous learning. I mean at the end of the day, that's what the staying power is, to make impact in this field and so when I think about what's the right starting set, I don't think there's any magic involved. I think it's a reasonable framework for the things we know today probably carry the most impact.

So when I think about the most impact, I think those areas are there and probably for the medical care delivery model, and it's been traditionally evolved, the area that's probably most lacking is the culture and the collaboration piece. So when I look at the spreadsheet that was created, I'm really not surprised on how it played out.

But I think don't be misled by the number of the things identified in terms of culture of equity, because that's where a lot is lacking big time, and ultimately it's also those other measures. Then it's the quality community, of professionals in the quality improvement space across the systems of care from a cultural standpoint owning this as quality improvement work, as opposed to a sidebar that somebody else does in the organization, but we're too busy doing quality.

This is quality. That's the critical paradigm shift in the clinical culture that we own this. It's part of it, and we have to make

this a quality measure, bring the same rigor, same discipline to this as we bring to any of the quality measures that we talked about.

CO-CHAIR PONCE: Thanks Ron. I have Susannah, then Emilio, Lisa Iezzoni, Sarah and now Nancy Garrett. Susannah, you're on.

MEMBER BERNHEIM: Great, hi. Two quick things, my reactions to what folks have said. First, I just want to echo something that Kevin said about with the balance of process measures and outcome measures, not assuming that we can't influence equity and outcomes. I think the experience of readmission measures, which people have strong feelings about but they were brought into a program and not only did hospitals at first think they couldn't really influence them, but nobody was paying that much attention to the equity thing, but the stink that hospitals were going to get heard.

What happened was that those national readmission rates came down, and there's now been two and about to be a third publication showing

that they went down faster in safety net hospitals than non-safety net hospitals. So we actually decreased the gap. So I think we -- I think one of the powers of outcome measures is that we sometimes learn we can do things once they're incentivized. So I think the same could be true with equity measures.

Two is I wanted to go back to Bob's comment. So Bob, I think is really important theme that came out about how do we protect the safety net hospitals on this. I thought Kevin, sorry Marshall said it was important that I think helps us continue to differentiate between issues of protecting and assisting safety net organizations, which has a lot to do with how measures are implemented.

So our framework clearly labels that as one of the goals, is to protect the safety net organizations and in fact the argument usually around risk adjustment is kind of in that box, right? How do we protect safety net hospitals from coming through?

How do we -- and I've often argued rather than doing it in the measure, how do we build penalty programs to protect safety in hospitals, to differentiate between them with the penalties? That is important, but as I thought Marshall said really well, that's really about preventing unintended consequences so there's not the other stuff that are our community is looking at that I think is really important, which is promoting improved equity, right.

Protecting the hospital just prevents the unintended consequences. But these concepts that have, you know, really looking at where there are gaps and eliminating those gaps and then incentivizing providers to close those gaps, that's the more proactive stuff, and that's where stratification of patients comes in, right.

So the risk adjustment is more about preventing unintended consequences; stratification if you do it well and you say look, this hospital has a gap in their black versus their non-black patients, and we're going

to, you know, incentivize and narrowing that gap, now we're doing something that's really proactive to improve equity. So I think that differentiation, which is important for us to reflect on.

And then I just wanted to echo a lot of what Ron just said, which I think was really good, but make one slight difference, because I feel like these domains that we have, and this is finally getting to the question that you guys want us to address, are very complementary and that organizationally you may want to move through them step by step, right.

You may need to establish culture in order to achieve those other pieces. But in terms of use of measurement, I'm not convinced that you would -- in fact I'm convinced we would not want to suggest that we start by measuring culture, because often, and sort of relates back to my first comment, if we measure outcomes, organizations dig deep and say that we have to look at our culture, right.

So I think that the -- in terms of how you sequence measurement, these can be very complementary. They can, you know, make people look more in areas that they need to, and I think of the third and fourth domain, which are access and quality, which includes in my mind outcomes of being the ends, right.

At the end of the day, what we're trying to do is have equal access and equal outcomes, and the first, second and fifth are the means, right. The way we do that is through things like changing culture and establishing partnerships. So if we were going to start about this set, that would be the framework I would use, that these are complementary, but they're sort of measures that are more about the means and measures that are more about the means.

So that's my recommendation for how to think about the domains.

CO-CHAIR PONCE: Thanks, Susannah. We have Emilio, then Lisa Iezzoni.

MEMBER CARRILLO: So going back in the

discussion, some of the -- I want to just add to some of the points that were made by Kevin and Lisa about the issues of community collaboration and partnerships. There is an example. I mean there are concrete, measurable frameworks that we can use, and I'd just give an example, collective impact.

I mean collective impact is used in the social sciences, it's used in the world of education, it's used in the world of social work. But collective impact has been applied to health, health care and it allows us a set of process measures such as what is the nature of the backbone of the collective impact group, the IT capability? What is the diversity of the constituents? What are the goals, what are the goals that achieved, etcetera?

So there are ways to concretized in a measurable framework some of these more abstract concepts, and just for instance, this collective impact straddles the other domains. It also straddles the culture of equity domain. So

that's just an example.

CO-CHAIR PONCE: Thanks, Emilio and we'll follow up with you as we populate our new measures framework. So next we have Lisa Iezzoni and then Sarah, you're after Lisa.

MEMBER IEZZONI: Thanks. This has been a really rich discussion, and I have no idea what to do with the stuff that's been percolating in my brain, so I'm just to going to reveal it. So many of the people that we're talking about who experience disparities are Medicaid recipients, and states differ in terms of the richness of their supplemental services that they support.

For example, the extent to which they cover transportation benefits, the extent to which they cover renovations of somebody's home, the extent to which they might allow somebody to get an air conditioner, the extent to which they cover personal care assistance. I just wonder the extent to which we might be -- some of our measures are going to be more dependent upon

people in the community getting these kind of supplemental services from Medicaid, so they can actually get the services or achieve their health.

I get the transportation. David, you talked about that a lot yesterday, even get to their medical appointments. So to what extent might we be disadvantaging some states where the benefit packages for Medicaid are just really, really thin compared to some other states, and how do we think about that?

CO-CHAIR PONCE: We're thinking about it. Thanks, Lisa. That's a great question, and we can come back to this with the Committee members. So we have Sarah and then we have Nancy, Philip. So Sarah, you're on.

MEMBER SCHOLLE: Okay, good morning. Thanks very much. This has really been a very helpful conversation. I agree. When I went back and read this was just domains and these descriptions, they resonate very well. I think it really does stand up as a very nice framework.

But I am also, I think I'm caught up on how do we measure the things, having a lot of experience trying to articulate what does the organization look like and how do you determine whether that organization has an adequate infrastructure?

We know that leadership is important. We can feel it, but it's very hard to measure. So I -- the comments from previous speakers about focusing on the end game, focusing on the achievement of outcomes or achievement of equity in specific measures, process measures that have very strong evidence base. That to me is a way that can generate focus and attention to all the things that have to come before, in terms of -- or that go alongside that, of building a culture where there is a desire to improve them and there's not a sense that well, we expect that for different populations we might get lower rates and that's okay because they're different populations with different needs.

It generates the impetus to develop the collaboration and partnerships to give -- the

idea of trying to think about measures is what are suitable for quality improvement versus what are -- what is better cited as accountability measures.

It's important for us to do this because I think while we agree and frankly, you know, there's a lot of I think qualitative researchers or organizations that improve on measures have a -- have strong leadership, have a strong cultural quality, a strong --

Those are things that are hard to measure outside of perhaps, I'm most convinced by measures that ask people that work in an organization about the culture in that organization. But even there it can be a challenge to implement on a wide scale in a way that's reputable and allows for fair comparisons across organizations.

So I'm a little nervous about saying that we're going to have measures about structure and culture that could be used in accountability, because I think the potential for gaming in those

measures is much greater than in the measures of end points. I also think we have to -- that looking at a core set of measures, where we want to focus attention will be much more convincing to a broader range of interests in this area.

So I just am very pleased to see this discussion going forward. I'd like for us to think about how measures can be used to achieve the end game, and where do we want to make recommendations about measures that might be useful for some kinds of internal purposes versus external purposes, and how as measures, as we think about trying to achieve equitable high quality care, equitable access that we think about ways that measures could be used to reward improvement or address the improvement that happens over time, rather than just a static comparison at a single point in time as well. Thanks.

CO-CHAIR PONCE: Thanks Sarah for raising those issues, and we're presuming you're coming back tomorrow when we get into that

discussion. So thank you. Nancy?

MEMBER GARRETT: So I just wanted to make a specific recommendation to consider about our framework, kind of building on what Sarah was saying about consideration of how we're actually using measures. Is it for quality improvement, is it for accountability, and then Susannah said we want to be incenting all providers to be improving on these measures, and then also guard against harm to the most vulnerable populations.

So if we look in our equitable high quality care category, we've got, you know, kind of our traditional set of quality measures in that category. What I'm wondering is if we want to look at the National Academy of Sciences report. One of the recommendations that they made is that we might want to consider categorizing measures as social determinant-sensitive or not.

So the social determinant-dependent measures was one of the subcategories in the previous disparity-sensitive measure category.

But I'm wondering if we want to actually consider calling that out and categorizing the measures in that group according to whether they are or are not, because then that provides a framework for starting to think about how are you going to use those measures.

And if it's how they -- if it's a measure like blood sugar control for diabetics, you might want to be really cautious about using that as, you know, in Bob's example, of a way that you might be moving large sums of money around away from the populations that need it most. So if we were to have that categorization within that category, that might really help advance the conversation about how the measures are used. So that's a specific idea.

CO-CHAIR CHIN: This gets back to your original question about disparity-sensitive measure issue. It may be what happened with it about even now. Part of the review of the disparity-sensitive measure part, I almost have Emilio's reaction also, where in some ways it

starting to get outdated, the way it was formulated at that time.

It was almost I'd say like very sort of like patient -- well, let's say, blend the patient to the field and that it's too harsh. But it's like it's almost it gives the organization more of a pass, I think, in terms of like that so sort of like communication sensitive. So like very patient-focused.

But again this broader issue of like well, if a system isn't designed to take good care of the patients, the way it was worded, some of the disparity-sensitive bullets sort of was straying away from that. So I guess it's like the issue too, like the socially sensitive --

CO-CHAIR PONCE: Determinant-sensitive.

CO-CHAIR CHIN: The social determinant-sensitive measures, it's almost it's the same challenge of the continuum. So depending on how you -- I mean the words can be very important because some things you might

identify as being more obviously socially determinant, sensitive; in others it's more subtle, again, Emilio's point.

So I guess that's my major concern about it, the current warning that we need to be a little nuanced about like -- in making sure that it's fair, in terms of like what folk -- what is the responsibility of the organizations it is the responsibility, or they don't get a free pass or faced which I think the current wording potentially could miss.

CO-CHAIR PONCE: Yeah, I agree, because I think lifestyle was an upstream condition, which does not seem like an upstream condition for me, because that could sit on the patient.

MS. O'ROURKE: Just a quick one. This is a great conversation, and again Emilio remembers this. I think he may have chaired the work group at the time that we were doing this work on the disparities. It was a while ago, and the reason why I bring it back up is there's some

-- there's some kernels of good stuff in there, but it needs an update.

I think actually what several of the comments have been we think we have to get away from saying these are to be used to identify measures that should stratified. I think we've moved beyond that as being the only tool in the shed, and perhaps it's really that we're trying to come up with measures that are equity sensitive, that would fit into these domains.

And maybe we then think about the criteria maybe they fit this domain. So just thank you for advancing our thinking, which is why we wanted to put it in front of you again. Thanks.

CO-CHAIR PONCE: Thanks Helen. Philip.

MEMBER ALBERTI: I'm trying to tie together so many of the threads of this incredible conversation so it will make more sense to me. So I feel like the domains that you've listed, these five or six domains, kind of

are the road map. So I mean maybe it's a cul-de-sac, right, kind of loops back in on itself and it's both sequential and self-reinforcing, that the more you do the work, the more the culture improves, etcetera, etcetera, and it's kind of a chicken and egg scenario. So that's kind of one thought.

And in terms of, you know, accountability and, you know, I can't imagine that we're going to make recommendations, you know Romana. We're talking that CMS is somehow going to reimburse for fomenting a culture. But I wonder if, you know, in service of the third and fourth domains around access and quality, where that seems to be more on target, there are some concrete recommendations about the kinds of measurements that we propose in the stratification of the adjustment or whatever, and we can provide tools and the resources for the other domains on what, what have other institutions done to kind of create the culture? Where are the systems that we think are in place

to do this work, that could be part of the needs assessment that Ron was talking about.

So I wonder if it's a balance in this report of both kind of formal recommendations about measurement and accountability programs, but also a set of tools and resources and a research agenda to kind of move the conversation forward.

I think to Lisa's point, you know, a strategy I think for all -- and to Michelle's point about making this both central and not trying to add new work. So I think if we really look at kind of -- and I think we've done this already, and thinking about these five health areas that are kind of common community health needs across the country, thinking about the metrics that are already in use in a routine way, identifying those across the country that are being used already, that are central to reporting, to really then identify those that are social determinant-sensitive, disparity-sensitive, whatever we're going to call it, and

targeting those as the first pass for measurement could be both a way to make sure that it's central to everyone's work, and we're not asking someone to do something more, just do something different that they're already doing.

And then the last point that I wanted to make is really picayune, and I know that the visuals will change. But in terms of the arrow, the collaborative arrow across the five domains, I would really urge that that extend beyond that fifth concentric circle, because right now all the partnerships, it looks like they're internal partnerships, and there's nothing actually extending beyond the institution's walls in kind of the current visual.

So it looks like the culture to the quality, all of those are internal kind of measures, but that partnership and collaboration, I think we really need to stress that they extend beyond the hospital and to the community and other sectors. So those are some points.

CO-CHAIR PONCE: Thanks, Philip. Very

helpful. Traci and then Michelle and then back to Emilio.

MEMBER FERGUSON: Yeah. So I was going to address Lisa's comment, in terms of the Medicaid, the state agencies. What we're seeing now is that, you know, depending on what stage, depending on their funding, they may have a richer benefit plan that, you know, looking at fee for service.

But then a lot of these states are reaching out and opening up their membership to managed care organizations, and requiring that they have value-added benefits, and looking at ways to innovate in terms of, you know, transportation, looking at health care education, what they're going to do to improve that community connectivity.

But I think that this would be a great opportunity for this committee to give a framework of what would be sort of expected if they are looking to try to sort of improve for their Medicaid population.

CO-CHAIR PONCE: Lisa on this point.

MEMBER IEZZONI: Yeah, and I jumped into the line to answer that. Yes. In Massachusetts, you may have heard of the One Care Program, which is like what you just described on steroids and we, you know, wanted to offer a very rich transportation benefit initially but it just got to be really expensive.

And so if you limit the dollars that you give to programs to try to control costs, you're simply not going to be able to cover all these things. So I think that this is actually a very, very important policy context, that we need to wrap everything that we're talking about in because the people who experience social determinants of health and social risk factors are Medicaid recipients.

CO-CHAIR PONCE: Thank you. Michelle.

MEMBER CABRERA: So building off of this conversation, if I may get into conversation, Traci, I do think that part of what we should be trying to do in how we explore, you

know, the packaging of our recommendations is to think about who's buying what we're selling, right.

I do engage some with purchasers, live purchasers like our state Medicaid program, as well as payers like health plans. We hear the way that they're thinking about things and talking about things. I think if we put out sort of a road map, it doesn't really impact the conversation at all at that level.

And so we really need to hold their hands and I think we need to tailor a lot of what we're doing to different kinds of purchasers. So there's a Medicaid conversation around disparities where maybe adjusting for income is not the point, right. But adjusting for -- looking for racial and ethnic disparities is way more influential and important than it was in our conversations about Medicare, right.

Where we found yeah, no, the income level stuff is the predominant. But I don't -- I feel like we've barely scratched the surface on

the Medicaid side and yet Medicaid is following full throttle the directive of CMS on the Medicare side.

So I worry that we are going to kind of miss this, and then that's not even starting to talk about the commercial private side, right, where who knows what's going on, but likely it's some mix of all of the above, right.

So I do think that to some degree we do need to be mindful that -- of these two points, that there's a purchaser-specific framing for the conversation, that I don't think that large purchasers and payers understand, or will seek this out for the most part, right, even large purchasers with significant populations, where there are significant disparities.

And so we -- I hope that part of what we can do is move a step beyond this to really figuring out a way to walk them through what they should be thinking about, and how they should be applying some of this stuff.

CO-CHAIR PONCE: Thanks, Michelle. So

building out that road map to hand-holding, tailoring future directions, future areas for research is also what Philip said. Emilio, thanks for waiting so patiently.

MEMBER CARRILLO: (off mic) Sure, sure. You're talking about leadership and, you know, how you measure that better. That came in years ago --

CO-CHAIR PONCE: Emilio, please put your microphone on, and then repeat what you just said. Back to the future.

MEMBER CARRILLO: Yes. The spirit of Back to the Future, to 11 years ago the report "A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency," which Helen was right there ahead of the curve, we had -- the first domain was leadership, and there's actually a set of five preferred practices that help define leadership, for example, which are measurable.

For example, seeing that culturally competent care is reflected in the vision goals

and mission of the organization, implementing strategies to recruit, retain and promote at all levels of the organization and diverse leadership, ensuring that fiscal and human resources --- et cetera, et cetera.

So you know, it's been thought about and it's in the NQF world view, so we can look at that.

CO-CHAIR PONCE: Thanks, Emilio. Bob.

MEMBER RAUNER: I'm going to follow up on Michelle's comments and then trying to figure out a tactful way to say this, but we can have a really rich discussion around this with this group. But when I'm sitting across the table from the CMO or a commercial plan or somebody from our state Medicaid department, they're starting at a much lower level on these issues.

So part of the challenge I think we need to -- although CMS is our primary audience, Blue Cross/Blue Shield needs to hear these and the state Medicaid folks need to understand these disparities issues. But the same with -- you're

starting from a much more elementary level when you're talking with your commercial plans and payors about this stuff.

So we need to -- I want to -- I'm not sure what the solution is, but they are not in your health plan. You have to like almost explain basic statistics to these people sometimes, and so they don't understand bias and risk adjustment and social determinants. We need something for those groups to bring them up to this level of conversation at some point.

CO-CHAIR CHIN: I've got a question for Helen based upon Bob's comment. So we have this immediate September 2017 deadline for finishing this project and report to CMS. Do you have any vision or sort of thought for what the Committee does sort of after that charge?

MS. O'ROURKE: I think it's something we'd like to talk to you about. I mean we've made a commitment that this is, and I'll turn to Elisa. This is, you know she runs the place really so we made a commitment. This is a

standing committee. It is not -- it has not been stood for this one -- that sounds really bizarre. It was not stood up for this one project. It is intended to have a continuous life at NQF.

I think as we did for the year before we got HHS funding, it won't go away. We may just not have dedicated funding in the way we did in the prior year, unless we can find additional funding or talk with our CMS colleagues to thinking about whether there's a Phase 2. Lisa, this is really your bailiwick. Do you want to add anything?

MS. MUNTHALI: No, I'm sorry. My voice is almost going. Helen is right. We've had some good conversations with CMS, so we are hopeful that they will continue funding. But this is a commitment through us at NQF, and we'll find the resources, perhaps not to the level that CMS has been able to support us over the last two years. But we are very hopeful about the conversations we've had with them recently.

CO-CHAIR CHIN: You know, I guess more

specifically, are you going to mention a fairly narrow charge in terms of like internally, like NQF issues and like recommendations of other committees, and the input of this -- by our standing committee, versus some of the things I've just mentioned.

So for example like I guess it was Bob and it was like Michelle that were talking about like the wider payer communities, both governmental and non-governmental, and then creating materials or tools or a process that influences that. That's a much more external-looking focus.

So is there any guidance regarding internal/external balance, or are we open on this at this point?

DR. BURSTIN: I think anything's on the table. I mean I think there's a real opportunity. I know Derek Robinson, HCSC, just did an equity summit recently. So I know there is some interest in the -- certainly we've got Kaiser, we've got other financiers, interest in

the payer community. So we'd love to see if that's a possibility.

But again, as we think about the work of MAP, The Measures Application Partnership for example, that recommends measures to CMS for different federal payment programs. I very much think this committee would be a critical input into the way that measures are recommended for selection. Does this measure bring an equity balance?

Marshall was the subject matter expert on that, to try to bring that perspective. We could build it into the criteria that we use to recommend measures to CMS, you know. Then your work has continued effort through our other core processes. How does this get built into the endorsement of measures? How does this work, we'll talk about tomorrow certainly around social risk adjustment.

But even, you know, identifying those top gaps that will emerge out of this is something we can then work with our incubator on,

and see we can find external funding to get some of this done. So we really see this, as you guys are intentionally cross-cutting with an expectation that you influence all of our work going forward.

So I wouldn't feel limited by internal versus external and again, this year we're really fortunate to have the CMS funding, and I think we are able to kind of build the work you already wanted to do around it. But our hope is that your work is not constrained, that you continue to serve as what we need, which is a cross-cutting influence on our work to make sure disparities are not the after-thought, but are core to the discussions of quality.

CO-CHAIR PONCE: Thank you, Helen. Romana.

MS. MURPHY: So I wanted to get back to I think a point that Ron raised, in terms of one size will not fit all, and health care organizations that leads to different stages of whether they can actually focus on specific

disparities reduction initiatives, or whether they really need to get that buy-in from leadership.

And so, you know, I know there were a couple of comments and I can't attribute all of them, but I was kind of just percolating on this, and you know, I think about my role. I started at Denver Health in January, and you know, after all these years of working on disparities, it's the first time I've been, you know, in the room with the C suite listening to what gets reported, going to the board to report to the board.

What I can tell you about Denver Health, and I know that there are others here from safety nets and from other health care organizations, what I know is that there is a lot going on, and I think it was a comment that was we can give a road map, but if we don't do some hand-holding there's, there is, you know, we're kind of going to miss the mark a little bit.

I think about the road map, because I know there have been other road maps. When I am

sitting in, you know, executive staff meetings, nobody is talking about a road map. But we are hearing about all the different initiatives that are taking place within the organization.

We are hearing about the contract that we had with Lyft, to bring people to Denver Health. I know Denver Health is involved with the, you know, the 1-2-3 Equity Pledge. So my point being that there are pockets of work taking place in health care organizations, but they don't know how to kind of roll it up to oh, this fits into this framework or this road map, or this is how this connects to payment reform.

So my question is, you know Helen, and I think, you know, what you said about this being a standing committee and where we go next. So you know, when our work is done here, I don't know if NQF has ever done this. But is there any capacity to collect information from, you know, a handful of organizations that we know are doing really great work, but it's kind of scattered within the organization and it isn't attributed

to or tied back to a framework or to a road map, and really ask them to do that, so we can see the body of work that's taking place.

Because I think what I'm recognizing is that there is, but we're not connecting the dots well. We still think about this very much from the deficit model, you know. That's kind of the framework, and I guess I'm kind of saying, you know, is there a way for us to compile some of the good work that is happening and tie it to what our recommendations are and the road map that we're developing, because I think it makes it much more concrete.

It also acknowledges a lot of organizations that are doing a lot, but they're not connecting the dots. So you know, when I bring this up in a meeting, I get kind of like "Oh, wow, that's fascinating," because they are so involved in terms of what is working within their own institutions.

DR. BURSTIN: It's a great suggestion, Romana. You may have just helped us write the

follow-up proposal to CMS to continue this work. I think it's a neat idea to actually see how this road map, how it connects to what people are actually doing on the ground and how it could be useful, and again, we don't want this to just sit on a shelf. We want this to be truly disseminated and used.

I think it's a really interesting idea. It would also be great to understand how, for example, if equity measures increasingly get into pay for performance, how does that change the dialogue at some of those meetings? I mean we really need to understand. For a long time we've talked about if only we could push some of these forward in the way people flip out over readmission and sepsis measures at institutions, how do we get them to have the equal response to a measure that says language interpretation skills are available within X number of minutes is I think going to be a really interesting challenge for us. I'd love to better understand the implementation science, not just the here's

what needs to happen.

CO-CHAIR PONCE: Thank you. Christie.

MEMBER TEIGLAND: Yeah. So I was part of yesterday's conversation and today's conversation, and this whole concept of this sort of disparities that we're not seeing in the Medicaid populations, and we call that moral hazard in economics, right, and it's sort of unobserved.

But it's this moral hazard idea that, you know, if you have access to more benefits, you're going to probably use them, and that's why we might see, for example, the result I reported yesterday, which is when you look at medication adherence and you adjust for duals yes, they're less likely to be adherent to their medications.

But when you add income in there, because of all the disparities in benefits across states and eligibility requirements, a dual does better than a poor person, and I've talked about this before. But I really think -- and then we have this whole debate about Marshall, the

business case, and people kind of took affront to that, you know, that well, it shouldn't have to be a business case. It's a moral case, right.

Well actually it does, and you know, and in the ACA, for example, there's the lowest level of benefits that you need to provide. It's a minimum. I don't know how they came up with that, but it seems like we need to look at that perhaps as a measure. I mean what is the minimum set of benefits that are required to have good health outcomes, and maybe that's a quality measure.

Maybe who's looked at benefits, right? I mean we know what the benefit packages are for Medicare Advantage Plans. We know what the benefit packages are for all of the different choices you have in the current version of the ACA. But no one's studied that very much in terms of how that relates to outcomes, and but we clearly know there's a connection there.

Then there's this whole concept of who pays, right? I mean we're talking about

providing transportation and education and, you know, helping people get their GED. Well that's saying that HUD isn't doing their job and Education isn't doing their job, so now health care has to pay for that?

Really? So who, right? I mean how do we -- how do we connect all those dots? So benefits seems to be critical here, these benefits packages. There might be some minimum level. I mean how do you measure that? How do you quantify that in a way that will assure we can actually close these moral hazard gaps that we're not really able to observe?

CO-CHAIR PONCE: I think our standing committee is going to be here forever as we consider this, until it's fixed. Traci and then Phil.

MEMBER FERGUSON: Yes. This is a comment just to expand on Romana's comment about, you know, calling for organizations of what NQF can do next, that if you have organizations that are willing to open themselves up, who are doing

initiatives may not be sort of connected, then they want to take it to the next level, be able to sign up for NQF consultation to assist in doing an evaluation and assessment once we have again that road map to be able to see, you know, over a period of time.

If we give them guidance, will they be able to, you know, whatever the domains that they have to focus on and work on, can we as an organization help them facilitate, because you know, it's hard doing it within the organization, to you know, have that expertise. But if you have all of these minds together being able to say, you know, we have -- whether it's a cohort of people going through this in different organizations, and that I think will make our road map a living document as we see, you know, improvements and this works with this type of organization so --

CO-CHAIR PONCE: Thanks, Traci. Philip.

MEMBER ALBERTI: I have a really quick

point and then maybe a longer point that piggybacks off of what Christie said and some of the conversations yesterday. So the quick point is the AAMC, with some AHRQ funding, has been developing some tools that I think speaks to what Romana was talking about, in terms of how an institution can build a systems approach to community health and health equity.

And so I'm happy to share those and we can maybe talk. Maybe that's a next something to leverage going forward. Christie's conversation just now about social services, the partnerships. So I talked a little bit about this yesterday at the NAM event, kind of thinking what our goal is, right? Do we think that the expectation that we should have for hospitals health systems is that there are never any documented disparities in any outcomes?

So I don't know if that's a reasonable assumption. So I was tasked yesterday with some others to think about how we would measure health equity, right. So if health equity is this

everyone has an equal opportunity to avail him or herself of his or her full health potential isn't hindered because of socially derived circumstances?

You know, these process measures we're talking about really speak to a hospital or health system's actions to create that opportunity, right, to create an equal set of traces for all patients, if we're thinking about health care opportunity, or for all members of a community if we're thinking about kind of health opportunity.

So even in this perfectly equitable system where Patient A and Patient B from very different SDS backgrounds, if they have the same set of choices available, we've attained a state of health equity or health care equity if we're talking about the choices inside a hospital's walls. But those individuals could still make different choices, right.

And so we still might see group differences in health that aren't in equities or

not related to social disadvantage, but they're kind of these dry disparities, differences in health that aren't pinned to a decreased set of opportunities or choices due to social advantage.

So I just wonder, I don't know if we need to be as philosophical as I tend to be on this issue in the report, but you know, what is the goal, what is the expectation? Is it complete, you know, equality, or is it really equity of choice, opportunity, ability to be as healthy as I personally choose to be and I'm not hindered, and what does that look like in terms of measurement and how do we adequately capture that?

I just -- it's kind of a little bit of a monkey wrench, but it's something that's really pressing on my mind on these days.

CO-CHAIR PONCE: Philip, I wanted to thank you because I think that helps us segue into the next part, which is the guidance for developing equity measures. So I'm going to ask Erin to continue with that. Oh, I'm sorry. Ron

and Michelle. So Ron, then Michelle.

MEMBER COPELAND: Good. Just a quick point, that Romana's and Christie's comments just reflected. When we talk about this business case and the traction that sepsis and other things have gotten in the quality community, one of the reasons they've gotten so much traction is because the financial or economic impact, in addition to the quality components of it for people's health, but the economics is a front and center issue because in hospital systems and so forth, people got claims and they can see this is costing X amount of dollars and we've got to -- it's a target because of that.

When I, the last few times I looked at the literature over the last four or five years around have people put dollar amounts or economic impact of disparities, the literature is almost non-existent.

I think part of -- so when we talk about incentivizing focus, accountability and so on, one additional area that's not necessarily

part of the scope of this current work, as we think about future contributions and so on, anything we can do or encourage that will help quantify the negative, the impact, the economic impact of allowing disparities I think is -- would be another important contribution to this area.

Because in a resource-constrained environment, which we certainly are in terms of health care, people are following the money. So if no matter what moral arguments and population health arguments are made, if people don't see it, are unable to translate that into what's the economic impact that is causing me by ignoring and not playing in this space, right now that's an empty set.

So people don't get motivated or incentivized. So any way we can contribute or encourage industry or otherwise to put some dollar amounts to this work, I think would help the cause big time.

CO-CHAIR PONCE: Michelle, did you

have a follow-up on that?

MEMBER CABRERA: Yeah, thank you. And just to say to Philip, you know, I want go down that rabbit hole with you so bad, because I think, you know, that this issue of like equal opportunity to access health care, if I am a health system and I'm doing me and the patient shows up and I'm like wow, it didn't work for you so clearly you need to do something different, right, that is not achieving health equity, right?

The point of this should be to drive a conversation not about sort of equality to opportunity, but it should be to drive the conversation to uh-oh, there is a problem and I need to look first at what is my role as a provider in that -- in fomenting or supporting or allowing that problem to persist.

I think the point should not be for the providers or the systems to take on all of that burden, but for them to see what part of that problem are they able to address, right?

And if they put their back into it and if they change things, if they do things differently and they put their everything into that problem as a sub-component of the overall quality picture, can they make a difference for that disparity and then by extension for everybody else they serve, right?

So it's somehow trying to incentivize flexibility through that accountability, right, and a willingness to experiment. But I am overly cautious that like we need to be careful about the passive response to some of this work, and the possibility that people could just say well, it's not me, right, because I did everything I could to make sure everybody had the same opportunity.

And I know that's not what you were thinking because you are so down, but you know I just -- I just wanted to clarify that.

CO-CHAIR PONCE: Bob.

MEMBER RAUNER: I know we need to move on, but I do want to throw a little counterpoint

in there. You know, two specific examples for Nebraska disparities on seat belt usage and colorectal cancer screening. There's huge disparities east and west, and the reason our longevity in western Nebraska is lower is mainly seat belts actually.

Now I'm totally okay with being incentivized on that, but making a physician accountable for that is a little different, and that's the kind of follow-up farthest point off. However, the same thing could be said about colorectal cancer screening. Our usage is 13 percent lower west and it's going to hurt those doctors on their MIPS scores. But should they really be accountable, because some of that is cultural actually.

Some of it's lower health insurance and lower income levels accounting for that. Most of it's actually cultural. I grew up in western Nebraska. They're very fatalistic about their health. They think it's my time, it's my time, I'm not going to do that. So at what -- so

I'm totally okay with incentivizing, but I think you have to be a little careful when you deal with accountability.

So that's a little bit of a counterpoint to that, because then you're talking about free will and whatever. It's very philosophical and maybe that's a discussion over a beer tonight but so --

CO-CHAIR PONCE: Okay, Erin. Can you take us to the next section? We do not have a break until lunch.

MS. O'ROURKE: So if you do need a break, please feel free to step out. We know we scheduled a grueling morning, since we have a lot to get through. So for this next section, I don't want to belabor too much on the slides, because I think we've already started to go there. But we're hoping you can help us think through within each of the domains, on some more concrete ways of how we could measure that, and start to assess what we call measure concepts.

So it's getting to a little bit more

than just an idea. So we defined it as an idea for a measure that includes a description of the measure, including a planned target and a population, obviously with the caveat that we're not tasked with measure development here, but rather just -- so we'll ask you how we start to assess these domains and what are some measures that belong here.

I do want to be cognizant of the point that Bob and Kevin made too, that this is also a bit of a renewing exercise. We don't want to necessarily recommend 150 new measures, but rather how can we maximize what we already have. Are there certain measures in play that the Committee thinks are particularly important to assess, starting to maybe put in place what that core set that a number of you have mentioned would look like, thinking about, from each domain what do we really want to assess, and then what's that right balance of structure versus process versus outcome.

So to start you thinking, we did a

little bit of a homework exercise that we can screen share. Thank you very much to those who were able to complete it. So we think we just want to walk through a little bit, domain by domain, share what we've learned from the homework. I think Philip you sent in ideas here, so we're going to tell you that you're on point a little bit.

Just to start to think about some of your ideas and then perhaps we could open for a full Committee conversation on -- starting with the domain of cultural equity, what would we really want to focus on for developing measures in this domain.

MEMBER ALBERTI: Sure. I'll happily kind of walk you through my again convoluted, philosophical tortured thinking here. I don't know if there are any measures that I propose that are really right for like accountability, and most of them are binary and don't really have denominators. So that's not really keeping in the spirit with measurement development.

But thinking about an institution's culture that would facilitate kind of a focus on health and health care equity. So it is explicitly included in the institution's mission statement and/or strategic plan, with real accountability that rolls up to senior leaders or the C suite through measurable goals, milestones that are really talking about creating a system that creates health care equity.

Is there someone at an institution whose sole job it is, or the lion's share of his or her role, to really think about these system-wide efforts to create connection across the institution that focus on equity.

And in terms of an institution's advocacy work or community advocacy/government relations, is the institution kind of walking the walk via comment letters, what it's advocating for locally or federally. Are they targeting community health and health and equities?

I mean the only the one that maybe fits into a traditional metric in terms of safe,

accessible, a safe and accessible environment for all would be some kind of threshold proportion. I'm not sure what that would look like, in terms of faculty, staff, etcetera, from under-represented groups, however we chose to define it.

And so I think I collapsed the sub-domains. There's a lot of overlap between these five domains and so it might not be as clean and clear as we had intended. But those at least are my initial thoughts.

I also will say that there's a parallel process, and I think I shared this survey with Marshall and NQF staff, that folks at G.W. are thinking about the social mission, how to measure the social mission of health professional school.

So it's not quite the same unit of analysis and that stems from Fitzhugh Mellon's (phonetic) earlier work. They've gotten some funding from RWJF to really think through what a culture of social mission would look like and how

you would measure it. Some of these are pulled directly from that.

That might be another tool for us to look at if we're thinking about maybe not accountability in this space, but developing tools and resources and guidance and hand-holding to think through some of the actions an institution could take to push forward a culture of equity.

CO-CHAIR PONCE: Thanks, Philip. I know as you said, this was a hard exercise, but you got us through this since --- and I thought this exercise, at least for some of the domains, was about discovery. It's still like a discovery phase of can we come up with some concrete measures. So I know the measures I've proposed have no evidence.

I mean I'm not sure if there's evidence base to it, but again it was just this first try at trying to come up with a policy handle, an accountability handle. Romana and then Ignatius and then Lisa. Oh I'm sorry, Lisa

Cooper first then.

MEMBER COOPER: Yes. So thanks Philip for leading us off on this. One thing I would definitely add, having been named as an individual at an institution specifically charged with, is that that's actually not adequate, that I would definitely add something around resources being clearly allocated to the work. So evidence of budget, you know, and resource allocation to the work. So I'd definitely add that.

The other ideas that came to mind and I'm not -- I think they fit in this domain, relate to a lot of organization do surveys of organizational culture. So for example, you know, we've actually used measures where we assess perceptions of the staff and faculty, and stratify those perceptions by demographic characteristics.

And so some sort of regular assessment of the culture of the organization by the organizational stakeholders or personnel I think would be one that we could easily add to this

domain. So I think those are the two things that came to mind.

Oh, the other thing I thought about was, and it may have been mentioned in the report, is that I thought that committee that Emilio and I were on that was -- that came up with the different domains for organizational and cultural competency, I thought as part of that work, there was an instrument that was commissioned and developed by G.W. was it?

Was that mentioned in the report as a measure that could be used? It is? Pardon me?

DR. BURSTIN: The Speaking Together measure set of G.W., or something different?

MEMBER COOPER: Is that the name of it? I didn't think it was called --

MEMBER CARRILLO: It was the Weisman, Betancourt, myself, Green, MGH, that did a study of the measures and that was a couple of years after we did our work.

MEMBER COOPER: Yeah. But they came up -- like somebody at G.W. like got a grant to

develop a measure that would map to the domains that we -- oh RAND, okay.

DR. BURSTIN: RAND, and that is endorsed, and I believe that's captured here, yes.

MEMBER COOPER: Okay all right. So I think that's one that could be used and we could look at scores on that measure.

CO-CHAIR PONCE: Okay, thank you. Romana.

MS. MURPHY: So I just wanted -- I had whispered to Ignatius, and maybe this was referenced or not. I don't remember, I didn't look. But at least the top three of these, the top three measures here, there is a lot of work that was done that Ignatius funded when he was at the California Endowment, looking at, you know, issues around mission and other aspects of kind of leadership.

So those reports are still out. There was one specifically from the Joint Commission on hospitals language and culture, and then a second

report on language services. The reason I'm calling that out is because a lot of the work there was qualitative and pulled out what organizations were actually doing in terms of implementation of some of the measures that, you know, that Philip has identified.

So that might just be a good resource, and I know the work is -- I can't believe it, but it's in some cases more than ten years old or ten years old. But I think it's still relevant because it pulls up specific examples of organizations that were doing it and tries to make some connections to more downstream metrics.

CO-CHAIR PONCE: Thank you. Ignatius.

MR. BAU: So to pick up on some of the earlier conversation about Medicaid, I'm wondering whether it fits here or it will fit more in the access. But I do think there is a notion of is the health care organization participating or active in expanding the ability of people to get to them as health care providers.

So it could be something like are they a Medicaid provider. So we know in a lot of states a lot of providers are dropping out of the Medicaid program because the reimbursement rates are so low. So again, this would be a way that they would actually get a credit for being -- sticking in a program that is obviously expanding access to individuals who experience disparities.

Similarly if they're a health plan, are they participating in a state health exchange or the federal health exchange. So again, are they making that affirmative decision to actually expand access to care to folks. And so again, I don't know whether it fits culture or it fits in access, but I think the ability to actually call those things into play would be also different but easily measurable.

CO-CHAIR PONCE: Okay, thank you. Lisa and Bob, then Nancy. Oh sorry, Lisa, Emilio, Bob, then Nancy.

MEMBER IEZZONI: Okay. I know we've defined equity before, but I think when we talk

about the culture of equity, so everybody's on the same page that we need to very clearly define what equity means so people understands that. So Bob, you sent me down the rabbit hole yesterday actually, because you made a comment to me somewhere, or maybe even to the whole group and I just took it personally, about how equity needed to be of -- that if you saw any disparities that related to people's choices, people's preferences were operationalized because everybody had the same opportunities.

So if you saw differences between groups, those represented -- if you had achieved equity, those would represent true differences in people's desires for different types of processes of care or outcomes. Is that -- did you say something like that, because I have a follow-up comment if you did.

MEMBER ALBERTI: I said there's the potential there, right, so for expecting differences that are based on social disadvantages, you would hope those would go away

and if there are any remaining differences, they could be due to all kinds of different things individual or group choice or culture, as Bob said, that it's a possibility.

MEMBER IEZZONI: Okay, and that's what sent me down the rabbit hole because I think for people who've been so disadvantaged for so long, thinking that they have a choice or feeling that they have an opportunity is going to be a really hard place to get to. If people would bear with me for just a minute while I give an example.

We -- our research group was the only research group to use SEER Medicare data to look at the under 65 population and disparities. Everybody else just says oh we exclude people with disabilities. They never explain why. We were the only group that we did, and we found the following.

For women with early stage breast cancer, women with disability under age 65, women with disabilities were 24 percent less likely than other women to have lumpectomies. In other

words, after you adjusted for all the cancer characteristics that you could with the SEER Medicare data.

Otherwise, women with disabilities were a lot more likely to have mastectomies. Now does that represent their choice or what is the reason for that? And so let me just tie this out a little bit, because we then looked at the women who'd only had lumpectomy, both women with disabilities and women without. People know that for women who have early stage breast cancer, to have the same disease-free survival with lumpectomy, you have to follow up with radiation therapy.

That's where we found that women with disabilities were 17 percent less likely to get radiation therapy after lumpectomy than were other women. So that's a clear quality problem.

Now then I got another grant from NIH to talk to women who have physical disabilities, who had had early stage breast cancer, and I got for example the following story from a women with

cerebral palsy, that every time she got put on the radiation therapy table for her XRT, that they had a velcro strap to strap around her waist to keep her in place.

But she had of her arms because of her cerebral palsy, and they masking taped her arms down to the table every day. They didn't have velcro straps; they masking taped her. So for her to think that she has the opportunity to, you know, she might have been so upset about being masking taped down all the time that she might have just -- if she had known that that was going to be the case, she might have just chosen to have the mastectomy, because at least that way she wouldn't have had to have dealt with masking tape every day, you know, after an eight week XRT.

And so that's why I think that we need to unpack this notion of equity and around choice and around -- so sorry. That's the rabbit hole you sent me down yesterday.

MEMBER ALBERTI: I think that's a

perfect example. I mean to me that's an inequity. That is a manifestation of social disadvantage of injustice, and that -- I would expect that the QI processes in place would address those very issues, correct.

MEMBER IEZZONI: They just don't get it. They just don't get it, and frankly I'm just going to say this. Especially when it comes to disability, my experience yesterday presenting to the conference is an example of that, that they just don't get it.

MEMBER ALBERTI: You know, I think the others that we talked about in service of understanding and unpacking equity was the importance of this Committee's work and all the other various kind of groups tasked with this, to do this work in a patient and community engaged way. I think we will really miss those opportunities to think through the unpacking if we're not actually asking and working with and partnering with the people that we're trying to serve in these processes.

MEMBER IEZZONI: And about this qualitative research, I know that people are really embedded and wedded to numbers. But to unpack what's going you actually need to talk to people.

And so I would like that to be part of the message of what we're -- what our report is going to come out with here, that if you see a disparity that you need to talk to people, and you need to just not talk to them in a survey, but talk to them in a two hour, open-ended, semi-structured search interviews, you know, where you really give them the opportunity to describe what's going on in their life and their thinking.

CO-CHAIR PONCE: As always, thanks Lisa. We have Emilio next, then Bob, Tom, Lisa Cooper, are you still on or on the queue?

MEMBER IEZZONI: No, I've had my turn.

CO-CHAIR PONCE: Okay, and then Michelle. So Emilio.

MEMBER CARRILLO: Philip, thank you for taking the lead. I think that the measure

domain, the sub-domains that you have pointed out are right on target. They are institutional. They're all institutional. There are other institutional sub-domains that we can find in the 2007 NQF report.

But we need to look at institutional. We need to look at systematic, systemic and organizational, and we need to look at the individual.

So those three realms of sub-domains should be included and we would work on that. An example of the systemic or organizational would be measures of how to include the various different pieces of the puzzle, like the community integration, the neighborhood as a unit of measurement and what takes part in the neighborhood.

Those are things that can be measured through collective impact measures that we talked about earlier, and individual measures again that a lot of them are in the lexicon of cultural competence and patient cross-cultural

communications. So I think that we might want to look at those three domains as we look at these sub-domains.

CO-CHAIR PONCE: Okay, thank you. Bob.

MEMBER RAUNER: Just going to follow-up on Phil, I really like these domains, and then of course Lisa mentioning that there needs to be funding specification. I think a great data source that could accomplish that is the Community Health Needs Assessment for Non-Profit Hospitals. I think that's a way under-utilized policy tool.

Right now, some just look at it as a checkbox on their Form 990 and not much more, and if put things like this in it, that would actually accomplish a lot, I think.

CO-CHAIR PONCE: All right. Could you talk more about that?

MEMBER RAUNER: Well, non-profit hospitals, as part of their Form 990, they have to complete a community health needs assessment,

which specifies what they're doing to improve the health of their community. A lot of them it's -- I've literally had a hospital CFO tell me that they just did that because it's a checkbox on the Form 990.

It should be a real thing that actually specifies what they do, what they're funding. It has a lot of potential, because all non-profits have to fill that out to justify their non-profit status. I think that's a great policy tool and you could use that as a great data source because that's a public document essentially.

CO-CHAIR PONCE: I see, for accountability. Okay, thank you. Tom?

MEMBER SEQUIST: So this is a great lesson. I just had a couple of questions or -- I'm wondering as we think about these are -- these measures of the culture of equity and the numerator things which are all great things for an institution to be doing, if we wanted something that could also reflect what we were

hoping these upstream activities would lead to.

So having health equity as a part of your mission statement, and having senior leaders engaged in this. If we had some measure that they were then -- or having someone whose role is to be accountable for this stuff in the institution. If we had some measure that things were happening because of that, short of reducing disparities, which would be the ultimate thing.

So I'm thinking about things like are they actually -- and I don't know which domain this fits into, but I was thinking it may fit into this domain.

Are they actually measuring and reporting equity measures? Are they being transparent about equity measures on their public websites? So we all have to be transparent about CMS measures, because CMS is already transparent about them.

But right now we don't have to be transparent about stratifying those measures by race and ethnicity. But what one would think, if

you have senior leaders engaged in this, you're trying to hold people accountable for this, that things like that would be a reflection of -- things like measuring, reporting and being transparent about equity measures would be a reflection of that.

The other comment that I was thinking is the bottom one, the diversity of the workforce. I think it's great. I really wonder about faculty I'm assuming means the sort of practicing physicians in sort of an AMC framework.

I guess what I would hope for is actually that the board room and the executive leadership actually has that diversity, whether it's women, minorities or other under-represented groups I actually think is just as important as the faculty being diverse or the physicians in your group being -- the physicians, nurses.

We probably should change that to clinician. I mean it's all of the clinical areas. But I really think it's actually we want

to say specifically that the executive leadership. That is actually I think one of the goals. I think someone referenced that AHA Pledge for Equity, that sort of 1-2-3 pledge, and one of the things is diversity of the executive leadership.

CO-CHAIR PONCE: Thanks, Tom. Michelle and then Eduardo on the line, then Nancy.

MEMBER CABRERA: I'm sorry to ask this, but I'm trying to understand what is it that we're going to do with this set of concepts?

MS. O'ROURKE: Sure. So they're basically some illustrative examples to help us flesh out the domains. CMS was looking for guidance about how they could actually start to implement these. So what would the Committee like measurement to look like in these spaces?

MEMBER CABRERA: Okay. So we will be turning a version of this over to CMS?

MS. O'ROURKE: Yes. We're collecting all your thoughts and then we'll put that in the

fourth report.

MEMBER CABRERA: Okay. So I think yeah, I will say we do need to I think work on this obviously a bit more, and add some teeth to it, especially because again I'm not trying to be cynical. I just have seen this play out where organizations will say "We will embrace health equity" on their paper, right? It's like totally there.

But then the truth is that it's not. So reduction of disparities as part of quality improvement might be one, you know, proposal for how you effectuate this, right, that your quality improvement strategies, in addition to stratifying include disparities reduction as a subcomponent of quality improvement somewhere.

And then yeah, that's helpful. Thank you. Just thanks.

CO-CHAIR CHIN: If we look back at the structured sub-domains, I think that some of what you mentioned Michelle and what Tom mentioned are in there, but we can make sure the language is

clear, yeah.

CO-CHAIR PONCE: Nancy.

MEMBER GARRETT: So I wanted to build out Ignatius' comments about the -- some additional measures we might think about that touch on domains beyond the providers. So I think these are great provider level measures. So but looking at our model, what are some community measures that we might think about.

And so I like the idea of is it a Medicaid expansion state. So our Medicaid patients, do they have that equal access to benefits, and then kind of building on what Christie said earlier, maybe there's even a measure of kind of an essential benefit set for Medicaid, and does the state have that or not, and that could be an interesting kind of culture, and maybe gets into the structure of equity domain as well.

Other ideas might be what's the ratio of Medicaid to commercial payment in the community or in the state? That's a source of a

lot of inequity and how resources are distributed, is that for the same services, commercial insurance reimburses much greater than Medicaid.

So what's that ratio look like, or Medicaid to Medicare payments. So is the Medicaid payment adequate to cover what that population needs could be a measure, again at a community or state level.

Then even thinking beyond health care, what about social service spending in the state or in the community, and what are those levels and are they adequate to really address social determinants of health. So I was talking to David yesterday about Detroit and we were saying, you know, there -- in some cases there just aren't the social services to partner with health care, so what do you do?

So that could be a health equity measure. If that community isn't offering those resources, then that's an equity issue. And then thinking about health plans, either private or

public, are they offering payment enhancements for vulnerable populations? Like is there a payment enhancement to take care of homeless populations differently than non-homeless populations, and that could be a health equity measure as well.

Again, it could be looking at your public payers or even your private payers and that would really change the conversation, if that were something they were measured up against.

CO-CHAIR CHIN: I have a quick question for NQF staff. One thing that was asked about is who's the audience? So for example some of these measures may apply to plans, some may apply to individual providers. Some of these you mentioned really are national. You mentioned the point about if you're a Medicaid expansion state or not.

So to staff or to Helen or Elisa there, if we're going to -- who are -- who's the audience and if we are going to take a number of

stakeholders to describe in more detail, in terms of like relevant measures, how would you prioritize?

MS. O'ROURKE: Sure. So what actually Drew and I were just whispering about was that it seems like we're checking a little bit along some of the ways that NQF thinks of measures on level of analysis, like I think Nancy you were just mentioning some great potential population level ideas.

But I think there's also a role for health plan measures and what we can assess them on as far as what they're doing to promote equity. And then I think drilling down those measures we would need at the provider level, perhaps even going all the way down to the individual clinician.

So I think we can think about this, you know, going back to the socio-ecological model that we showed at each level, and thinking of how NQF assess measurement at various levels of analysis, what concepts, what tracks so that

everyone is perhaps being assessed on the same underlying concepts, but in their own way, if you will.

DR. BURSTIN: Right, and some of this may get into some of the crispness we talked about this morning. Like do we actually specify, for example, the level of analysis. Do you specify the potential uses might be something this group might want to weigh in on some of these, which could be great at a national level as we mentioned.

Some of them could be great as a health plan level measure for improvement. You know, I think that's an opportunity for the Committee to be a bit more detailed.

CO-CHAIR PONCE: Eduardo.

MEMBER SANCHEZ: Good morning. Thanks for calling on me. Really, really great, great discussion and really, really great points that are being made.

I think the idea of the CHNA with core health equity questions might be something that

we could and should explore. I really love the idea and the comment not only on participation in Medicaid and Medicare at the individual system and hospital level, but also the payment side.

And as the conversation was had about national, state or where the focus is, Medicaid payment is a state-determined policy decision, and I think there's some pretty good evidence that there is an inverse relationship between payment and participation, in addition to other factors that might weigh in.

I hadn't heard and I just wonder if the notion of relationships with FQHCs might be something to consider as something that could be measured, to include hospitals and specialty groups on the clinical side of things. As somebody who came up FQHCs and understands that and Bob, please if I'm wrong because I'm out of date, please correct me.

But relationships with hospitals are critical, and one of the biggest challenges that FQHCs have is getting access to specialty care.

So those individuals who are in FQHCs already are disproportionately challenged populations for a variety of reasons, are sometimes being taken care of by great primary care docs, but who are practicing at a level that is not the standard of care in a community, because access to specialty care makes it difficult for specialty care. Outcomes suffer.

And then lastly those -- I think this is consistent with something else I heard. In addition to the relationships with FQHCs are financial arrangements made in such a way that it eases the burden on individuals who may go see a specialist, but isn't necessarily getting FQHCs pricing. The same goes for the hospital. I'll stop there. Thank you.

CO-CHAIR PONCE: Thanks, Eduardo. All good thoughts. I think some of them also could apply to the other domains, in terms of access. I did have a question, and I'm not a measure developer. It's triggered by what Nancy said. There are some measures that are built in but

then there's binding constraints, for example, you're in a state that didn't expand Medicaid.

Can some of the -- what we're trying to achieve be through the measures as an indicator, but then accommodating these constraints, these policy constraints, or you don't have a very strong community infrastructure for the wider net of social services? So can that be part of it?

So it's not necessarily built in, but then you account for these policy and local community infrastructure constraints.

DR. BURSTIN: It certainly could be. The question is oftentimes is there a better proxy for those that you can build into a measure that would work across the board.

Is it really then about income? Is it really about patient risk as opposed to those other factors. But some of those could fit into the access domain as measures as well in and of themselves.

MEMBER GARRETT: And if I could just

quickly respond, I was also thinking about, you know, United Healthcare does this flashy report about the healthiest -- like they rank all 50 states on overall health and then they do a press release and they have all these different measures. Maybe we could do a health equity ranking of states based on one of these health equity dimensions, and you know, something that gives that policy attention to the places where we are actually hurting health equity through some of these macro policies. So that could be a measure set in itself.

CO-CHAIR PONCE: It's a good idea. It's just like we have a diversity index for companies, and companies -- I'm on the board of one of them, and they really care about moving up from 49 to 48, you know, they want to be in the top 50. Okay, thank you. Philip and Ron and Emilio.

MEMBER ALBERTI: One additional comment on this last little conversation. It could also be a way that these metrics are

reported, right? So you could use those variables to stratify reporting. So for Medicaid expansion versus non-expansion states, or for states where there's a more equitable ratio. I mean you could look at it that way as well. So you're actually comparing the right places to the right places.

CO-CHAIR PONCE: Thanks, Philip. Emilio.

MEMBER CARRILLO: Just harkening back to the discussion about how to measure a sort of community services adequacy, I think a source of data and concepts could be the Accountable Health Communities Program or CMMI, which is just kind of a launching where there could be measures of a connection between a patient and a FQHC or the health center, with a particular, for example, a legal aid CBO that provides support with housing and transportation, et cetera. So there might be some good grist for the mill there.

CO-CHAIR PONCE: Thanks. All great ideas. I hope NQF staff have been recording this

away, and it's not also over, as Michelle said. This is going to continue to as we populate these tables for the pre-work. There's a comment online. Oh, it's Kevin, sorry. Kevin, go ahead.

MEMBER FISCELLA: Hi. Yeah, just to echo some of the thoughts that have already been expressed.

Certainly looking at diversity and improvement in diversity over time among the C-suite and certainly the board of directors, I think is an important one, and that would include not just all the standard measures of diversity that we've talked about, but also for example Medicaid participation, given how much of a share that represents in many hospital systems.

The other -- the other issue I think that if systems were to report on this and there were some transparency around it, I think it could promote real change, and that is the segregation of care by insurance. I think if that were public, I think the systems would begin to look at how to do that and that not only

creates differential access in some cases, for example if you're Medicaid, your wait time might be less.

You might -- I know hospitals where if you're commercial you can even get a concierge valet parking. If you're Medicaid, you don't get that. The wait time to get a visit may be different and who you see may be different. It may be a trainee as opposed to a faculty.

So I think reporting on that could -- really could help to change both the culture but also equity in terms of resource allocation in meaningful ways.

CO-CHAIR PONCE: Thanks, Kevin. So I think you're saying so the stratification helps as what Philip said in comparing like groups to like groups. But then you also want to not lose the stratification of care by insurance by payers will illuminate that there's just different, different access.

MEMBER FISCELLA: Well segregation -- I'm talking about within the health care system.

So segregation of care. Essentially, if you have Medicaid, for example, you would go to a "clinic" as opposed to a faculty practice, where the waiting times, the continuity, the amenities and so on would differ widely. That fosters a hidden curriculum for all trainees in terms of the, you know, patients of different socioeconomic status, different backgrounds are treated differently.

But it also results in meaningful differences in access to resources within that system.

CO-CHAIR PONCE: Yeah, thank you.

MS. O'ROURKE: So I know we started to touch on some other domains, so -- but just to show the ideas that people have come up with, could you scroll to the structure for equity, and there's a volunteer from this group. Christine, maybe you want to share some of your ideas?

MEMBER TEIGLAND: Yeah, I agree. This was hard. This was a hard exercise. So I basically started with, you know, the sub-domain of capture resources to promote equity and

thought about the whole issue that we just don't have the data, right? So it was mentioned yesterday that perhaps, you know, Medicare would require on admission to Medicare to, you know, capture information about -- capture this information and keep it in the enrollment file, right?

And other plans could do that as well. So maybe it's a social risk factor survey and you collect data on income and home ownership and education and race ethnicity. Some of those things change though. So it would have to be sort of an updated thing, but you know, at least maybe we could track with some type of measure. You've got all your health plan members enrolled, and did they complete the survey?

I mean how many actually did you collect this data for, so that was just a thought. Went on to the second one about collection of data to monitor the outcomes of individuals with social risk factors, and we had been working on this child core set of measures.

So this measure struck me as just an illustrative example of, you know, of how these measures are done. And so, did they even go? Did they see the doctor once a year? Did children ages 1 to 19 have one or more PCP visits during the year?

Well, when we looked at that, and so the idea here would be to stratify that obviously by some of these social risk factors, because when we looked at that, you know, people with lower incomes were much less likely to have even at least one PCP visit.

But what I started to think about here was the fact that these denominators, to be fair, always these require continuous enrollment in a health plan for 12 months, with a 45 day gap. Well guess what? It's those people who are in Medicaid and in the ACA who are constantly dropping out. They do not have 12 months of continuous enrollment.

And guess what else? Those are the people who have the worst outcomes. That's where

most of these disparities are. So guess what? They're falling through the safety net. We are not tracking -- these measures are not capturing the full degree to which these disparities exist, because they are not even in your denominator, right? These people are not in that denominator.

How do we capture those people? They jump back and forth from Medicare -- Medicaid to ACA, to a health insurance exchange plan. Sometimes they, you know, the qualifications for Medicaid are very, you know -- you make a couple of dollars more on a temporary job you had, you all of the sudden qualify. You're out, right?

And so you qualify, you don't. We see a lot of churn back and forth between Medicaid and ACA. We really need population health estimates to get at what the true degree of disparities are for this population who are not enrolled in a health plan for 12 months during a year, and all the measures are defined that way. They all have some enrollment criterion. You have to to make it real.

So when we start to then think about the population estimates, that's when we need to start thinking about communities working together. So you know, we really need a variety of health plan, health information exchange, hospital, community level data. We need to actually exchange data to figure out where these two disparities are.

I talked a little bit about the hot spot type of analysis. New York City's been doing some of this, you know, and frankly there's some areas where asthma is your biggest issue, right? Some areas it's diabetes, and then to stratify those by these social risk factors. But unless we get to that, you know, population health measurement, where the -- we're not going to capture the full degree of disparity that exists because these folks just aren't enrolled in these health plans.

I also started to think about, you know, the ACOs and the development and the trend towards developing these narrow networks, right?

Narrow networks really means they're limiting services. They're really controlling access to care, and what happens to people who end up in some of those narrow networks is that when they need access to a specialist, they either don't get it, number one, or they have to go out of network where they can't afford it.

They get hit with these very, very large bills because the specialist is charging full price, right, for the services and they're not able to pay that. So that brings us back to the benefit issue, right, and the access issue. So those are just some things I was thinking about. You know, we really need, I think, to think about these population measures and that's sort of what all of the rest of this was focused on.

The last one about transparency, public reporting. I mean still you need to do that at the population level. But I really think we need to compare with a set of measures that have the exact same definitions, sort of across

these types of insurance, Medicaid, ACA, Medicare, commercial and are your rates different even for the same level of income, even for the same, you know, group that has disparities, because we see a lot of -- we see a lot of disparities and inequities, even within the same health plan across their payer type coverages, right?

So -- and we never see that. We never see, you know, a commercial plan on a specific measure compared to the Medicaid plan, because they say oh, well they're going to be worse, right? We don't see that. Maybe we need to suggest that that needs to happen. So those are just some thoughts I had as I was trying to work through this, but it's really hard to measure, right? It's all hard.

CO-CHAIR PONCE: Thanks Christie for doing this, and I think just even the last point reflects what Tom said about transparency and what Kevin said about looking through the whole system. Okay. Comments from the group. Bob,

Philip, then Lisa Iezzoni.

MEMBER RAUNER: I want to echo the -- I think one of the biggest sleeping giants for the safety netters is this churn issue, and it's even worse in a non-expansion state because you go to zero coverage essentially for intermittent periods of time. In our state, sometimes it's on a monthly basis even.

And so that's one of the biggest obstacles in the FQHC environment, and maybe you get the A1c drawn, but when you lose coverage for meds for three months, you're back again. So this coverage is a huge issue and then on top of that, what you mentioned about the narrow network provider issue, you might get insurance again, but the provider you used to have is not on the new one.

So you're bouncing between clinics because of the provider networks being too narrow and inconsistent. We would have this in our community where you get bounced from the GA clinic. Then you'd be over to FQHCs and you're

back at the residency program again and that movement added to the problem. And so churn, I think, is one of the big --

And again, go back to denominator, it's a year of coverage. Some of these people don't even get measured because they don't even have a full year of coverage and they're not in a place long enough to even get measured. So they're not even in the data a lot of times.

CO-CHAIR PONCE: Go ahead, Philip.

MEMBER ALBERTI: I think this is a really great start to this structure for equity domains. Just a couple of other things that came to mind would be something that really tops into what Romana I think was talking about is really the connectivity between these efforts. So health care delivery models that formally and explicitly address social determinants of health.

So that could be medical-legal partnership or a community health worker model or, you know, home assessments that take place or direct links to the community health improvement

work that's based and developed as a result of the CHNA. So kind of seeing movement in the SDOH space.

And then maybe something that also speaks to inter-professionalism, kind of inter-professional care teams, might also be an important structure that promotes equity.

CO-CHAIR PONCE: Thank you. Lisa Iezzoni.

MEMBER IEZZONI: I think that we should also think about the very Donabedian structure when we think about this too, because frankly having enough interpreters around or having wheelchair accessible weight scales. You know, that's something that Mass Health right now is talking to the Disability Law Center and other people representing people with disabilities, making sure that all plans that contract with Medicaid have wheelchair accessible weight scales and height-adjustable exam tables. I think that that's important.

I've been weighing whether I should

make a political statement or not. Am I allowed to do that? Yeah.

(Laughter.)

MEMBER IEZZONI: I understand that the 13 men locked in the room up on Capitol Hill right now are viewing people who churn out as never returning again, and putting that into the capitation for Medicaid. That's going to be devastating, because as Christie said, those people are the ones who are just uniquely vulnerable.

CO-CHAIR PONCE: Thanks Lisa. Tom.

MEMBER SEQUIST: So I was just going to, on the structure piece, I was going to mention structural pieces like availability of translator services that other things that would be important for equity. I also, one of the pieces that's I think important in here is our -- when I look at the bucket that was called -- it's not on the screen right now, collection of data to monitor the outcomes of individuals with social risk factors.

So I think somewhere in there are our ability that we've done two things. So one is we've put in programs to train people or have some process of how we're collecting this information, and then the other is that we have a way, I keep harping to Helen on this, that we have a way to store these information, these data in an electronic health record or some other format, because both of those are key and if you have one without the other it's not that useful to know.

On a postcard, everybody's preferred language and then the postcard gets filed away somewhere, which many of us have probably run research projects like that where you have all these data that are not useful, because they're sort of basically stored in your back pocket.

But to continue to harp on it, I feel like if you could get it into some measures that EHR vendors would start to have this higher on this list, because it's a really big structural problem in our ability to address this issue.

And then it's only through having those kind of data that I would know what kind of interpreter services I need, right? So I don't know if I need Mandarin because I don't know how many people speak Mandarin in my patient population.

CO-CHAIR PONCE: If you had a population-based survey, that could tell you.

MEMBER SEQUIST: Right, but getting the results to it then have to be stored somewhere, and we just -- most EHR vendors, and I know they're working on it, but it's just not easily stored right now. So it ends up a field called like "social history," which is then like a free text kind of paragraph that people write out all the important information that you would want to know about these risk factors.

DR. BURSTIN: I thought it was an MU requirement now. Am I wrong? I thought there was supposed to be --

MEMBER SEQUIST: It depends on the factor we're talking about. Some of them are and

some of them aren't. So clearly race and ethnicity for a very long time has been required to be collected in certain -- in actually using certain variables.

But some of the more nuanced stuff that we've been talking about here, that CMS has been looking at for risk factor adjustment, a lot of those things that we think are maybe even more powerful or just as powerful determinants of health aren't required to be collected.

MALE PARTICIPANT: There had been talk in service of Meaningful Use 3 of the National Academies and ONC endorsed a set of social behavioral psychological data points to be included on the vendor side, if and when MU 3, yadda yadda yadda.

MR. BAU: So it's actually now not MU 3, but it's ONC certification for 2015, and that is going to be a requirement in MIPS. So that's the back door or the side door that those things are going to happen. So I was going to follow up --

CO-CHAIR PONCE: Ignatius.

MR. BAU: I actually think if we get to the point where we're going to start calling out sort of the highest priorities within each of these domains and sub-domains, I actually think this data point that Tom was talking about is absolutely critical because conversations start and stop with our data systems just aren't able to collect, and so again structurally, that would be for me the absolute first thing any organization has to do is stop making excuses as to why your data isn't reflective of all these social risk factors.

And again, I think pointing to the ONC criteria, pointing to all these, you know, all the work that Romana did in the HRET tool kit, we have the tools. It is doable. You may not get to 100 percent, but you can't use that as an excuse anymore, to say that we don't know how to collect the data or it's hard to collect the data.

CO-CHAIR PONCE: Lisa Cooper.

MEMBER COOPER: No, I'm agreeing and I just -- I think also that -- that because there are so many factors that are now recommended, one of the things -- I mean I'm like for collecting all of them, right.

But I think we have to also prioritize what we're going to say is okay or at least provide like different stages of credit that people get for collecting various social risk factor measures, because they're not going -- people are just not going to do all of them.

I also wanted to ask if anybody else on this group is on the Brain Trust for -- the Epic Brain Trust because -- okay. So I know Epic is working on developing like a whole social risk factor module to be added to systems, and I'm not sure what the cost is going to be to different organizations to purchase that or have that plugged in so --

MEMBER SEQUIST: They will be able. So we have some partners, a bunch of people working on that. But it will be a -- it's

interesting, because it's going to be built into all these federal requirements. But we're going to have to buy it as a module and you have to buy the thing, and then you have to pay the people to plug the thing in, and as we all know it's not literally a plug and so we have to integrate in all the IT architecture that goes into that.

And it's been delayed -- for Epic it's been delayed. We were supposed to get it last year, and then they delayed it about 18 months. So we'll hopefully get it next summer. But we're waiting. We want it.

MEMBER SEQUIST: Right. I also want to just say that I agree with you about including some kind of measure of the training of the appropriate staff who do collect the data, and also like just to make sure that like there are -- there are designated people who collect that, because every -- like in our system, it's different people like everywhere.

It's not the same group of people, so you know, you need to know who's responsible for

collecting it or putting it in there, in order to train the right people.

CO-CHAIR PONCE: Lisa Iezzoni.

MEMBER IEZZONI: I apologize for sounding like a broken record. But this Epic Brain Trust person, where is that person?

MEMBER COOPER: Nancy is on it.

MEMBER IEZZONI: Okay. Is disability included in what they're collecting, because I would be actually surprised if it were and I think it needs to be. Again, this is one of the first things that I came onto the Committee saying, that the ONC standards did not include disability.

But let me just make the following point. If you have somebody who uses a wheelchair and needs to have a certain exam table and they show up in your clinic, you need to know beforehand to make sure that they're in the room with the right exam table.

And so to actually care for people with disabilities, you need to know what

accommodations they make, and our Epic model, Tom, from what I understand right now, does not really have a place where you can collect data that would allow the clinic staff that's scheduling patients to know what accommodations somebody's going to need, and so when they come in those accommodations are ready, just like you need to have the interpreter available.

And so I think that even though I know people are going to say like Lisa, I heard people say we just don't want to collect disability data. It's too complicated and so on.

Well, there are the six questions that the Office of Minority Health came up with as a result of Section 4302 of the Affordable Care Act, the six questions on disability that are a good start, and I would really urge our Committee to just make a -- if we're going to comment on this, to just make sure that that is included.

CO-CHAIR PONCE: Thanks, Lisa. Noted. Michelle.

MEMBER CABRERA: I don't know if the

CAHPS survey has any questions for consumers on an experience of bias or racial discrimination or other kinds of discrimination. Do they? No. So if I understand --

(Simultaneous speaking.)

MEMBER CABRERA: --you know, how is your experience, like that would be something too that we could suggest could be added as a consumer information.

MEMBER SCHOLLE: This is Sarah, just as a point of information. There are items in the CAHPS survey. They're just not used.

MEMBER CABRERA: Okay. They're just not used. Thanks. Well I think -- again, I think cultural competency is different like then -- yeah.

(Off mic comment.)

CO-CHAIR PONCE: Your mic please.

MEMBER COOPER: Sorry. Yeah, there are specific questions that ask about discrimination and there are specific behaviors that are assessed, like did people interrupt you

while you were talking, you know, act like you weren't like there, you know. I don't remember the specific questions, but they're -- it's included in the cultural competency supplemental item set, and it's a domain within that.

But you're right. I don't think every -- I mean people are selectively like not asking those now.

MEMBER CABRERA: So that could be one that we encourage the use of those measures to, you know --

(Off mic comment.)

MEMBER TEIGLAND: I mean I don't think -- it's not in the Star measures. So they may ask them, but it's not in a domain in the Star measure.

DR. BURSTIN: It's actually in a supplement, and so that is I believe voluntary. And so because of that, I think it's just not often used. I was just mentioning to Ninez, I think the last time we asked AHRQ to resubmit the supplement, they said they weren't supporting its

continued use, because I think it wasn't being used very often. We'll confirm that.

There is also one on literacy, is that right, Marshall? I don't know that they're doing that one either.

MEMBER COOPER: Well that's too bad, but there are -- the literacy and the cultural competency items are available. I mean, you know, they went through, you know, validity testing and that's where I think -- I've actually looked at the items and find some of them problematic but, you know. I think there was a lot of work done on them. I think it's definitely worth, you know, looking at them again and considering like recommending them, unless we want to propose the development of a whole new set, but you know.

MEMBER CABRERA: Right, or giving refresh, right? I mean I think, you know, if they're not being used because it's voluntary and it's a supplement, that gets again to this issue of sort of things not being baked in. If it's

that they're problematic and so people have concerns with the actual questions, that's another thing.

I think the point is understanding like, aside from other consumer survey questions, whether somebody feels like they've been discriminated against when they've tried to access health care.

That might be an important driver of change or conversation within a health system or a plan.

CO-CHAIR PONCE: And I think that that's a way of getting at the structure for equity. It's not -- it's unfair treatment within the health care system. It's not structural racism as Emilio raised, but it ensures that that handle is here in the structure for equity. So we can make that recommendation. Romana.

MS. MURPHY: So I have a question and a comment. So I know that Denver Health has been trying to implement collection of social risk factors, and it's been a real challenge,

partially because of the Epic issue and they just rolled out Epic about a year and a half ago.

So what they started to do is collect social risk factors through HRAs, and I know, you know, some of them hit on activities of daily living. They don't have a specific question and it's only in the Medicare piece. But they don't have a specific question on disability, right? I mean they ask about activities and, you know, capacity to carry out activities of daily living.

But I don't know how -- I guess that's my question, Lisa. Is that still too tangential in terms of the point that you made?

MEMBER IEZZONI: I think it's a place to start maybe. But I think that it would be good to go further, because as I said, as I said before, disabilities are very diverse, and to be able to think about the accommodations or what kind of discriminatory actions people might be confronting you need to know a little bit more, and something very generic like their ADL capacities.

CO-CHAIR PONCE: Lisa Cooper.

MEMBER COOPER: I'm wondering whether the NCQA required domains that are used for chronic disease measurement. I've seen, you know, the domains and they do, within the ADLs and the IADLs, they do have a lot of questions related to physical and mental health disabilities.

And I'm wondering whether -- I mean instead of do we want -- like I guess part of what I think Lisa Iezzoni is saying is that we need to actually ask everyone and not only limit this to people once they get referred into like some sort of special disease management program. Is that what you're getting at?

MEMBER IEZZONI: Yeah. Let's put it this way. Twenty percent of the American population has a disability. This is not a small number of people. It's 57 million people, and people might not be able to do their ADLs because of behavioral, serious mental illness, because of physical disability, because of sensory

disability, you know. There's going to be all different reasons.

That's why, Lisa, I suggest that people just go back to the Office of Minority Health, six questions.

(Simultaneous speaking.)

MEMBER COOPER: So we actually at Hopkins, we went back to the --

MEMBER IEZZONI: -- because you can benchmark from those, because the federal surveys have those questions in them, and so it's the benchmarking thing, yeah, good.

CO-CHAIR PONCE: Thank you. Shall we continue? It's five minutes to 12:00. So can you give us some guidance on --

MS. O'ROURKE: Absolutely. So we're a little behind, so why don't we do access as a domain, and then perhaps I think everyone looks like they might need a little break and lunch is out.

So maybe we could do the access conversation, break for lunch, quickly come back

to the table after you've stretched for maybe 15 minutes, and then we can finish the others, then have Sarah present and then we focus more on some of the implementation and policy recommendations for the afternoon.

Should we -- do you want to do public comment now or after we finish this topic?

CO-CHAIR PONCE: For the public who have got the agenda, maybe we should do the public comments now.

MS. O'ROURKE: Operator, could you open the line for public comment?

OPERATOR: Thank you. At this time, if you'd like to make a comment, please press star then the number one on your telephone keypad. We'll pause for just a moment.

(No response.)

OPERATOR: And there are no public comments at this time.

MS. O'ROURKE: Are there any in the room?

(No response.)

CO-CHAIR PONCE: Okay, thank you. Let's proceed. Access to care, and David, if you'd get the conversation started.

MEMBER NERENZ: I thought these were group assignments.

(Laughter.)

MEMBER NERENZ: What happened?

CO-CHAIR PONCE: There's a selection bias here.

MEMBER NERENZ: Where is the rest of my group? No. We can do this quickly, because you know, this was a challenge like others, but I don't think there's anything very remarkable in what I put forward.

I'll just say a couple of things in overview. I viewed the task as to come up with examples. That was hard enough. So I don't claim anything more than that. I don't think these are the best. I don't think these are, you know, just they're examples of what I could think of.

What I did try to do though is frame

the measures in terms of a clear, accountable entity, because you know this is a theme I've mentioned since we started the first meetings. But I think we have to keep talking about it, that when you have a measure, you can use the measure in two distinctly different ways.

You can measure a characteristic of a population, like do people in the population have access to care. Now you can do it for any population you want. But when you do that, there is no accountable entity so far. So you've got a measure, but it's not a performance measure and it's not an accountability measure.

Now it only becomes a performance or accountability measure when you link it to some named, identifiable entity who is supposed to be doing something. And then the measure is about the doing or the capability for the doing or the result of the doing. So what I tried to do here -- well, let me say. What I could have done or any of us could have done is to say, you know, let's measure some parameters of access in a

population, and it actually wouldn't look much different.

We have population surveys that do that already. Can you get a primary visit when you want it? Can you do this, can you do that, okay. But what I did do is say let's talk about the characteristics of an organization that relate to access. So that's what I did do. Now I'm not sure I even need to walk through the things. You can read what's on the screen faster than I can talk it.

But I was basically trying to come up with measurable properties or actions of an accountable entity, and you might think, for example, of a primary care network. These might apply to an ACO, Bob, you know. They're that kind of thing. They have to do with physical convenience, they have to do with scheduling convenience.

So I don't know. I'm not sure there's much more to say about it than that, but that's what I did.

CO-CHAIR PONCE: Thanks, David. So from a population perspective, we have a measure on giving an appointment within two days, which is a state, like a California state requirement. So I would set that, and also yeah. And also I think that that there is a role for a population-based measure as an anchor to these organizational measures as well. Michelle.

MEMBER CABRERA: You know, I do have to say that while in theory these things are within a provider's control, when you are serving a disproportionately high number of low income people and your margins are much lower or negative, then things like, you know, bricks and mortar where you site things or having availability of appointments, et cetera, I think become a lot more challenging.

And so again I think this is something that I struggle with. It's sort of like I think the accountability level for these sorts of things is at the payer level, rather than at the -- I mean if the payer is providing enough

resource to the provider and the provider's just sitting on a little pile of money then, you know, that's one thing, yes. Hold them accountable for this.

But otherwise I think it's actually a level up to -- otherwise, you're not comparing apples and oranges, you know, based on payer mix. You could have somebody with a fairly healthy payer mix who, you know, is making a choice to open up their brand new state of the art hospital across the street from another brand new state of the art hospital in an affluent area. That's problematic from an access standpoint.

But if you are rooted in the safety net, then something like this I feel like it just -- while it may show that there's a problem, it's not holding the appropriate entity accountable I feel like. Does that make sense?

MEMBER NERENZ: I guess I can just quickly respond, since my name got accidentally attached to this. No. You know, I would agree with the idea that there are plan level measures

that would speak to the broad concept of access. I would chose different ones. They might be payment -- well, different from those.

They might be not necessarily different from the ones you set. They might be payment adequacy, they might be the nature of the network, you know, has the plan gone to a narrow network versus not. Clearly there are plan level measures. I just didn't do them for this exercise, but they're there. But I wouldn't choose those measures and then apply them to a health plan.

Health plans don't have appointment slots, so can't do it. But other people do have appointment slots. Again, I'm not saying those are great measures.

MEMBER CABRERA: It just assumes that -- it assumes that you have something and that you're withholding it, whereas like if it's not there to give or to do something with then that's what I'm struggling with.

MEMBER NERENZ: I'll go a little bit

in my own defense because this is -- I'm in an organization that's located in the inner city of Detroit. It's what we do. There are a finite number of primary care slots. Some of them are scheduled in advance, some of them are same day or drop-in, and we have intentionally changed that. We've changed the mix.

We've changed the mix because we have a high no show rate in our inner city clinics, and this is one way to try to deal with that, and it reflects the fact that folks have transportation challenges, they have child care challenges, they have all kinds of challenges and it has nothing to do with the overall capacity. It just has to do with how do you use what you have. So I don't know. It didn't seem too bad.

MEMBER CABRERA: Thank you for educating me on that point.

CO-CHAIR PONCE: And David, your group thanks you for doing this. Bob, Nancy and Susannah, and Eduardo.

MEMBER RAUNER: Yeah. I just want to

talk a little bit more about Michelle's example, because it's a huge problem in our community right now, where we're a refugee resettlement community. So we have dozens of languages, and so the requirement with very good intentions that everybody wants to have, of course, is interpretation services for those appointments.

But that's actually unfortunately severely limiting access in our community right now, and the reason that happens is, you know, if you're a private clinic and you know your overhead's $55 to see a patient and Medicaid pays you $52 and now you have to hire an interpreter for another 40 that does not get paid by the payer, that that's basically economically impairing access to the very people who need it because of that requirement, because the clinic is supposed to provide it, but the payer does not pay for it.

And so what is happening is a lot of providers just simply won't schedule someone who can't speak English, because they know they're

going to get stuck with this extra $40 bill and it's an infrastructural problem, and that's the challenge. So everybody in health care agrees we should have interpreters, but until there's a mechanism to pay for it, that requirement is actually paradoxically decreasing access for these people so --

CO-CHAIR PONCE: Thanks, Bob. Nancy.

MEMBER GARRETT: So I wonder, Bob, on that point if there wouldn't be some kind of measure around that? So are interpreter services reimbursed in this community, in this state, in this health plan, and to what extent, because that's a really important access issue. You're right, that is a big issue.

So and just a couple other thoughts. I'm also thinking about not just care delivered in the clinic, but also to what extent is the provider being creative about getting services to populations. So are there community services being delivered outside the clinic system in some way.

Like we have a Healthcare for the Homeless Program where we do a lot at the library, because that's where our population is. So it could be like a binary measure yes or no, is this provider doing something in this category. So just a thought.

And then I also wanted to bring up, it came up a little bit earlier but there was a lot of controversy around a statement that the CEO of Mayo made late last year, and I don't know if this was like a national thing or just a Minnesota thing, but okay.

He basically said Mayo was going to give priority to privately insured patients over Medicaid and Medicare patients, and a lot of the health care folks in Minnesota were like well, he just said it but I mean most people are doing that, right?

So it was kind of this interesting conversation of the outrage of the kind of the reaction, but also the reality that probably there is preference going on because of the

economics of how this all works.

So I'm wondering if there would be some kind of measure of access within a provider for Medicaid versus commercial patients, whether it's their next available appointment, does that differ by payer type or something like that, where we could take one of our traditional measures and then segment it by insurance type to have an equity measure?

CO-CHAIR PONCE: That's a good idea, and I think it could also get at the virtues of stratification. We have Susannah and Eduardo. I have not forgotten you.

MEMBER BERNHEIM: Hi thanks. So one of the things I was going to say actually was very similar to what Nancy just said, which is that I think this concept of sort of looking at these access things by provider, as well as social risk factor, I mean by insurance provider and social risk factors would be valuable.

But so much of Bob's point, the finances are real and I feel like some of that we

can do with measurement. But I wonder if we should start to create a parking lot of, you know, financial policies. I don't think it's really right to measure --

I don't think we want to generate a measure that says our interpreter service is paid for, but we might want to have some addendum to what we put out that says here's some things you need to do to make it possible for providers to do this stuff, like ensure that interpreter services are paid for.

So I'm not quite sure how to handle that issue, and I don't feel like a measure is the right answer. But I think it's a really important thing to catalogue. And then much more concrete on the accessibility or the access to care and equity issue. One thing that we hear about a lot when we build measures around elective procedures is worry about whether different populations have equal access to appropriate procedures.

And so I think it would be good to put

that in this realm as a concrete place these could grow, and when we thought about how to do this, it's not easy because what you need to do is understand the population of people who might be appropriate to get that procedure and then look at whether they're sort of similar rates.

But I think it's an important place to go with measurement that's pretty concrete and that we could look at.

CO-CHAIR CHIN: Susannah this is Marshall, that your point about like some things may be appropriate for performance measurement and some things may be appropriate for other policy levers is a good one. In some ways, that after we have like this afternoon's discussion and then we then sort of put it together, we can have in some ways more of the pieces of the puzzle to play with in some ways, so that --

And so David Nerenz's point about like he came up with examples, not designed, intended to be comprehensive. In some ways that's -- you have to be realistic at this point for the time

that our Committee was given and all. Hopefully that by the end of this, we're -- we have in the afternoon discussion the use measures and then thinking about the final report, we can have some types of conclusions that look at it as a whole.

Then again, one of the problems in the past and challenges in the past has been that because we haven't been able to think about the full set of tools at our disposal, then you get into these weird solutions where you try to basically have a hammer to be a screwdriver. And so also that we'll probably revisit some of these discussions towards the -- at the end of the meeting, in terms of how that all fits together.

CO-CHAIR PONCE: Eduardo.

MEMBER SANCHEZ: Yeah. Earlier, I mentioned or actually earlier when I made some comments, there was some mention of blend, and blend is something we're going to have to get comfortable with, because I think that, pardon me, there's going to be some carryover and maybe these are -- these domains are not discrete,

discrete elements. They bleed over.

One example would be as I talked earlier about access to specialty care, for example, people who are in FQHCs. But quite frankly, my experience in Medicaid -- I apologize. I'm in a lobby. My experience with Medicaid is that access to specialty care is an issue there as well.

I had to sometimes send my patients hundreds of miles away rather than sending them to a local specialist. So that blends, I think though, not only access to care but the degree to which organizations make a commitment to make that care available is what I thought might be a culture, adopting a culture of equity.

Another place where there's blend it seems to me would be looking at things like the provision of clinical preventive services, and while that is a quality of care issue on the one hand, I think it's a proxy measure of access to care because having appointments is really important. But when it's all said and done, the

health outcome is really the thing that one is looking for.

And then lastly, in the same vein, when hospitals -- when clinic appointments, primary care appointments aren't available, the bleed over is that people end up in hospitals or in emergency rooms, and so I just wonder if we might not have a place for potentially avoidable ER visits and avoidable hospitalization visits as another access measure that actually bleeds over to our patients. I'll stop there. I apologize for the background noise.

CO-CHAIR PONCE: No, thanks so much Eduardo, and as you noted, some of those measures could also fit into the high quality care measurements, which we'll have a discussion after lunch. I do think the differentiation between payers, providers, community, maybe we need -- maybe under the notes section or another column on what the accountability lever is.

I think that would be helpful, and again this is an exercise for us collectively to

think about these different measures and again, we thank the groups and the group participants on this. Shall we take a break for lunch? I think lunch is here.

MS. O'ROURKE: I think you've all earned your lunch. So why don't we take a break and come back at 12:30, 12:35?

CO-CHAIR PONCE: Sounds good.

(Whereupon, the above-entitled matter went off the record at 12:14 p.m. and resumed at 12:36 p.m.)

CO-CHAIR PONCE: I think Traci is ready. I can see her geared up to tee us up in this discussion on high quality care, so go ahead Traci.

MEMBER FERGUSON: Yes. So when I was looking at sort of this domain, I realized that there were a lot of outcome measures across all of the conditions.

And so in focusing on the sub-domain, what I realized is that most of these measure concepts were process measures and how

individuals are performing activities to address or even identify if there were any social risk factors or disparities that should be addressed during the, you know, physician-patient interaction.

So I started -- there was three areas I was supposed to focus on. So I started on the person-family centeredness, and again looked to see if, you know, so the first one I thought of is -- is there, you know, the number of adults, again focusing on adults where there was documented, shared decision-making discussion that was occurring, that could be coded, and it would be across all of the patients seen during an annual well visit.

So again it's looking, because I'm not sort of on the payer side, again don't know the exact feasibility of how much of that information is captured in the current electronic health record. But if it was or there was a particular code, you know, F code or encounter data that we could document, that that would be something that

would be somewhat easier to capture.

And then part of the type of survey, you know, looking at kind of surprised that, you know, some of the supplemental questions in the CAHPS survey, in a lot of health plans it's part of the Star measures but being able to say that there are particular questions that should be included in the core set that will link up through the Star measures.

So patients who gave the highest rating for their provider when asked to give a rating of their -- the patient care provider relationship. So I was clear not to say necessarily a physician, because it could be a nurse practitioner, it could be a health coach or whomever that they were rating, and then it would then -- the denominator would be the total number of patients surveyed.

So, you know, it could be something that's already existing in terms of a particular question in the CAHPS survey or another patient satisfaction survey. Then looking at the social

risk factors, I think Christie did mention this, but if there was some documented social risk factor, I think Lisa also, factor assessment in the medical record that how many times of all the patients who had an annual well visit was this assessed.

So you're looking at -- again, it's more in terms of the process of identifying. Now again, there's a lot of outcome measurements that could be stratified. So I think this is just one portion of it in terms of the process. Are they doing the activities to identify any social risk factors or disparities?

And then effective interventions to reduce disparities. So there is, you know, in terms of how to address disparities when you're talking about community access and outreach and involvement of the community, being able to have, you know, community referrals addressing their transportation issues and what have you, but how can sort of you measure that?

So this would be both -- could be seen

from the pediatric population and also the adult population of the number of patients that there was, looking at the denominator. But the number of patients who had a community services referral, case management referral or with -- that's either within that practice or outside in terms of the health plan, consultation for social work or social services.

The denominator would be those with an identified disability, particular ICD-10 code for developmental delay and autism, you know, in terms of income. So that you would look at those who more than likely would need the social, or more community resources, how often -- there's documentation again in the electronic health record that you could see that this is happening at the provider level.

Then I picked another one for, you know, effective interventions to reduce disparities. Just looking at one of the -- in terms of hemodialysis. There is a similar measure that just looks at -- it doesn't go and

capture a lot of the sort of social determinants, but it does -- it's around that 18 to 75 with end stage kidney disease. So it's similar to another, another measure that's out there.

But I said with documented counseling regarding kidney transplantation, referral to a transplant center and being able to capture or stratify whether it's, you know, this rural versus urban, insurance status, race, gender, other comorbidities, ethnicity, primary language. So trying to, you know, see how with existing measures we could add a little bit more, to be able to see and be able to address some of the disparities that we do see in, you know, in terms of African-Americans being referred for renal transplantation.

And then I just had some general items, comments. In terms of when you're looking at more of the institutional level or sort of the system level, you know, how easy is it for -- in terms of, you know, talking about high quality care, and again with the person-family

centeredness, how easy, the ease with which patients can navigate their website, get information on this, how much they understand the health plan website handbook, benefit manual, the ease with which patients get information about their health and treatment options and how they understand their care, and how often the care provider includes them in decisions about their health care.

I would just ask a question in terms of is there any existing risk factor tool that would -- that you can incorporate into the electronic health record. That would be a way to capture transportation, food and shelter concerns, requests for additional help, understanding, you know, how to take their medications and, you know, really incorporating the health literacy screens and the health, electronic health record.

So trying to focus on things that providers already have access to in terms of electronic health record, and how we can in terms

of the concept in trying to address some of these more process measures. So that's what I came up with.

CO-CHAIR PONCE: Thank you. Thanks, Traci. Lisa Cooper.

MEMBER COOPER: So this is -- this is a huge domain so thanks for getting us started, Traci. I liked a lot of the measures you included on the person and family-centeredness, and when I heard you talking about the patient portal or something like that, I thought about just something that might be easy to capture would just be what percent of their patients are actually like signed on or logged onto the patient portal.

So you know, that's because a lot of times people get that information and then they just walk away and nobody ever uses it. So that might also be an indicator of how, whether they've actually made an attempt to help people make use of that tool. I mean having it is also a good thing, but then making sure that it's

actually usable.

I think what I'm wondering about is like so most of your measures are on patient and family-centeredness. Did you think about some of the other sort of more typical quality of care measures that might be disparity-sensitive that aren't in that domain? I mean, I'm just thinking about things that for chronic conditions, where we know that there's a disparity in care from the research and from the literature on outcomes.

We want to incorporate some of those, just those basic ones like, you know, the number of people who have their hemoglobin A1c like below 8 or 7 or whatever, you know, the number of like diabetes with that, with the number of hypertensives with their blood pressure meeting the goal, stratified by like ethnic groups, you know.

MEMBER FERGUSON: Yes. I think that one of the sort of the example --

MEMBER COOPER: I just chose one example.

MEMBER FERGUSON: That was in terms of the kidney. But being able to take those. Like you said, there are a slew of them that could be stratified fairly easily in terms of that. But then trying to find out well, what other things. So I was just trying to sort of fill in the gaps, the major gaps aside from stratification.

MEMBER COOPER: I'm wondering whether there are ways. I think it's great to capture to what extent people who we think might have a need for care management services are getting it. It would be nice if we had some way of measuring exactly some capturing the quality of that, of those services.

So I'm wondering whether if they have care management programs in place whether we could have people report on like the success rates of people that are in those programs, you know.

MEMBER FERGUSON: Yeah. I notice CMS when they're doing the D-SNP model of care, they're going beyond that. Before it was not

really looking at in terms of their auditing, in terms of the quality of the care planning, making sure that it's, you know, actionable outcomes and what, you know, that care manager and that care team is looking to sort of improve, if they have an issue whether it's asthma or diabetes, and making sure that they have, you know, a quality measure that they're aiming to focus on.

But that's a small population that, you know, in most health plans you may only of all the care, you know, Medicare Advantage, you only -- they only care manage really two percent of the population. So it is not a large population that is going to be captured. But being able to expand it so that we could see if there is any outcomes.

MEMBER COOPER: Right. So I just have one other thing. You asked a question about it, whether there are any key risk factor tools or assessments that would indicate that, and I mean I think there are a few of them out there, but the one that seems pretty good to me is the one

that's been developed by Health Leads (phonetic), and I think that's one that could be easily adapted.

Like actually we're talking about I guess a couple of different things, but certainly some of the questions from their assessment could be used to assess like needs for specific barriers to be addressed like transportation or housing or financial coverage for medications and things like that.

They have a really, I think a really robust measure. There's another one that the CDC came up with that is a little bit wonkier to use. But I think Health Leads really does a nice job. They have -- they've incorporated a lot of well validated measures into their assessment.

(Off mic comment.)

CO-CHAIR PONCE: Okay, thank you. And for your other question to Traci on how well a member or patient understands what their care provider health plan is, that is the CAHPS cultural competency module, yeah. Emilio and

then Christie.

MEMBER CARRILLO: So in the realm of high quality care, I think a possible perspective could be adverse outcomes, like medication errors because adverse events is a big part of high quality, and there you could probably come out with two or three branches of safety concerns.

CO-CHAIR PONCE: Thanks, Emilio. Christie.

MEMBER TEIGLAND: Yeah. I've been thinking about drugs and the high cost drugs. Again, there was a lot of talk about that at the AHIP meeting last week, and one of the things that Joe Swedish, who is the CEO of Anthem, you know said was there's a million dollar drug, and it can cure someone. It literally can, you know, it's life or death.

But that, you know, if one-tenth of one percent of his member population needed the drug, that it would add, you know, and this health plan has millions of members, right? It would add a thousand dollars per year in premium.

So those are really tough decisions to make. But that's an extreme example. There are even, you know, well known drugs, the EpiPen over the last year.

So access to these high cost drugs, I mean we're working with the Cystic Fibrosis Foundation and there are drugs now that can treat, literally cure in certain segments of the population, depending on your biomarkers. But they're hugely expensive, $90,000 a pill or something like that. So you know, for these high cost treatments, this is an access issue too I guess and back to the benefit design issue.

Is it covered? Are we -- are they only available to people who can, you know, afford them? So I think that's something else we kind of need to think about in terms of access and quality of care, for who?

CO-CHAIR PONCE: Thanks, Christie. Any comments from our members on the phone?

MEMBER FISCELLA: Yeah, this is Kevin. I would just echo the -- having a measure on the

cost of medications. We're doing a project on that now and collecting data. But that's a huge -- it's a huge issue and obviously cost related non-adherence is an important driver of disparities. So I would encourage collection on both the cost of -- both the out of pocket cost to patients as well as directly measuring cost-related non-adherence.

MEMBER BERNHEIM: And this is Susannah. I would just echo that. I think there's a big opportunity in looking at stratification of current measures, so that you can highlight the disparities that are occurring in current quality measures.

CO-CHAIR PONCE: Okay, thank you. Well, the opportunity doesn't stop here. Again, I think this is a big, as Lisa Cooper said, this is a big domain and I'm sure there will be other feedback and input from the Committee members. We're in collaboration partnerships, and I'm going to take chair's prerogative and ask Tom to present his.

(Laughter.)

MEMBER SEQUIST: So I super-struggled with what this how to translate this domain into -- I'm trying to open mine. Are you going to put it there?

CO-CHAIR PONCE: Can you speak a little louder?

MEMBER SEQUIST: Sorry. I'll get closer. Okay. So I only came up with very sparing ideas, because I didn't really have a good sense of how we would translate this into actual example measures. So the one was -- which seemed a little bit more straightforward to me in terms of measurement was the improved integration of medical, behavioral and other health services.

So you know, this isn't -- the way I defined it was more a -- it wasn't a sort of under-represented group-specific measure. This was just looking at the number of primary care visits that have co-located behavioral health providers, with the denominator being just all primary care visits.

So basically a measure that gets at access to integrated behavioral health care, and then the community and health system linkages sub-domain. All I could come up with was the presence of, you know, an actual -- this is sort of like as maybe even more back towards the cultural and structural measures we were looking at.

But had put that -- this is the presence of a community health benefits program or an officer, some sort of central accountability program for that. So I came up like really short on this.

CO-CHAIR PONCE: Before I call on Philip and Bob, I'd like to say that I have a lot. I came up with a populated list, but again that was just for me an exercise of discovery of what's available out there. I thought it might have been futility like this is measurable, but then when I heard Philip talk yesterday about the way to get to health equity is through community engagement and collaboration, I felt fulfilled

that I had done the exercise. So I wanted to thank you for that. So Philip.

MEMBER ALBERTI: I think this is a really important and challenging domain, and there's been a lot of scholarship out of the Clinical Transitional Science Award, the CTSA consortium on how to evaluate and measure kind of the quality of community partnerships, in terms of their ability to create local capacity for advocacy or for, you know, to build the capacity of local community based or faith-based organizations through partnership, and also some of the benefits that accrued to the health partner or the academic partner.

So that might be one place to look for a very clear metrics. There have been a couple of really great papers published. I'll try to find them and send them.

CO-CHAIR PONCE: That would be great. I ended up adding all of the resources as well under the notes section. Bob and Michelle.

MEMBER RAUNER: I'm just trying to

think of examples. The partnerships in the community health grant that CDC puts out, they actually specify which sectors have to be part of that grant. For example, you have to have education, business, faith community. Those might be some ways to do that.

There's a group in our community where the FQHC is pulling ethnicity-specific cancer screening measures, and then the local ethnic community centers, El Centro de las Americas, the Malone Center which is African-American are using those measures to actually monitor their grant.

So I think there are some opportunities to do those things, because there's some definitely CDC and DHHS funding out there that kind of fits with that.

So it's not necessarily coming from your health insurer, but there's a lot of grant funding that can -- this can work together with.

CO-CHAIR PONCE: Michelle.

MEMBER CABRERA: I have a formatting suggestion that you can take or leave. But I

almost want to flip this chart on its side and put the proposed measures on one side and then the domains that they could fit into on the other, because I think that some of these could go to more than one domain. So you could do like the dot dot for whichever ones could cross different domains.

So that's one idea. If other people disagree, you know, that's fine. I do think here too, just so the -- it's a site tweak to some of what's already in here. But this concept of hiring community workers, whether they're promotoras, navigators or community health workers from the communities served is actually an important distinction.

I heard about a health plan that hired like recent college grads giving outreach to homeless populations, and I'm like oh, I don't know. So I think there's some of that and the lived experience stuff that we see on the behavioral health side with peer specialists as well. I think just encouraging that kind of -- I

understand it's built into culturally tailored or whatever, but sometimes it's -- people don't, right, interpret it that way.

CO-CHAIR PONCE: Okay, noted. I think -- how should we go about this? Lisa, Lisa Cooper.

MEMBER COOPER: So I think it's implied here but what about just -- well first of all just the existence of a community advisory board, and then you know the representation of it I think is helpful like in terms of like the number of organizations or number of sectors represented.

Also, the extent to which or whether or not that board is co-led by a community person, along with the institutional leader, because I think a lot of times what we see is we have the convened groups.

They're lead by somebody from within the organization and the agenda is completely driven by that as opposed to actually having co-leadership. So I think those would be, you know,

reasonable to capture. There could be some sort of an annual like assessment of the partnership by the stakeholders and if, you know, there are some tools out there and somebody may have said a little bit of this, because I got distracted for a minute.

But that could be used for that purpose, and either we could just have the metric be that they have such an assessment that they employ on an annual basis, and/or if we can identify one that we really want to endorse and we can look for some sort of a threshold score or improvement in that partnership assessment.

CO-CHAIR PONCE: Great, thank you. Romana.

MS. MURPHY: So Lisa, I think that's a great idea. I do think that we -- there might be a need to be specific about this. Again, it depends on the organization and the size of the organization.

But a lot of organizations have community advisory boards for specific projects,

right? So there may be, you know, six different community advisory board types of entities residing within one organization.

But the one that I think in this context is more meaningful almost is a community advisory board that cuts across the organization, and has some kind of reporting mechanism to the C-suite or to the board, because I think that just instrumentally makes a difference, because a lot of the ones that have, you know, we're the community advisory board for this specific R-24 project is very different.

MEMBER COOPER: Yeah, try like maybe 50 or more.

MS. MURPHY: Right, yeah, right, right. So again I just think some specificity, because I think that's a really easy checkmark, because a lot of organizations have, you know, either research community advisory boards or community advisory boards for a specific initiative. So that's easy to check but it doesn't actually cut across the organization.

MEMBER COOPER: So maybe institutionally supported --

(Simultaneous speaking.)

MS. MURPHY: Yeah. That's the word. Yeah. That's the word, yeah.

CO-CHAIR PONCE: Yeah. I think this is what's getting us to like how do we get these broad constructs to be -- to really show authentic collaboration, and by adding specific language, specific -- that it's promotoras and these community health workers are recruited from the community, I think that would be really helpful for NQF.

I think all of the ones that I suggested that are less qualitative but more a handle is whether the organization actually puts dollars in the community. So I think I heard that yesterday and you just said you just incorporated, you know, put dollars in safety net. It may not be at the moment a great business proposition, but it shows a true commitment of your ACO.

And the other is, and I also got this idea from not a speaker yesterday but from Michelle Jester from the National Association of Community Health Clinics, Centers, is that it's having community information systems. There are some models. She mentioned San Diego County, which I can't wait to go find out more about that.

But this -- the systems where you do have the social welfare agencies with the health agencies have -- not only is the data system unified, but they all get together and do something about it. So it's this learning system of what to do as a county for the most vulnerable population.

So I thought investment, you know, actual investment in the community and investment into infrastructure to get at the other sectors of outside health. Philip.

MEMBER ALBERTI: Just to build on that a little bit, you know, now you brought to mind kind of the principle of the anchor institution,

right.

So thinking through an institution's kind of financial investment from its own kind of portfolio and local businesses, in making real efforts for job training and then direct employment at the institution, and then some measure of --

And I think this is also tapping into what Lisa Cooper was saying, community residence, you know, real hand in developing these programs so it's truly a partnership. And so I think the financial investment piece is an important one to capture.

CO-CHAIR PONCE: Thank you. Traci.

MEMBER FERGUSON: I did want to go back to sort of the partnerships, the improved integration for the medical behavioral health and also the oral and I would include pharmacy. I think co-location is the first step, but that doesn't necessarily mean that, you know, a member who may have a serious mental illness or an active dual diagnosis has -- that they both have

the information.

So I think maybe looking at those and we classify who, you know, actively have some diabetes and schizophrenia what have you, that in -- say if you're going to start with the primary care doctor, that they have record of communication with the behavioral health doctor, or that there's been some type of collaboration between or consultation with.

I think co-location is good, then consultation and then being truly integrated, whether it is that, you know, who's taking the primary lead in the case and that they have an active communication with that other entity. It could be at the, you know, physician or institutional level, but is also at the care management level too.

So I think truly, truly integration means that there is an active communication and being able to capture that and not just that they're in the same office.

CO-CHAIR PONCE: Thank you. Michelle

and then Nancy.

MEMBER CABRERA: I just want to piggyback off of what Traci is saying. I think the idea of partnership and collaboration kind of needs to start at home, and if you can't, you know, talk to yourselves or across departments, it's going to be really hard to do that outside of your organization.

So you know, whether there are interdisciplinary care teams or even workforce engagement around different initiatives, I think, is really important in terms of partnerships and collaboration.

Remember with Kaiser, it has a really great model on unit-based teams. But those sorts of things can really help to get you to that, you know, quality of the collaboration that's happening internally and influence what happens externally.

CO-CHAIR PONCE: Thank you, Nancy.

MEMBER GARRETT: So one of the barriers that we all face in addressing social

determinants of health is actually being able to connect to the resources and knowing what the resources are in the community. So I think that might be what you're talking about in San Diego. But we're working on a community resource database sort of that has -- it has lots of different stakeholders helping to build it, and then everyone's going to be able to use it and there's going to be an IT platform with it as well.

So maybe that's something to have a measure around, to incent communities to build that kind of database to have it available, because these resources, they change all the time, it's to have like the right resource at the right time is critical to helping people.

CO-CHAIR PONCE: Thank you. Any comments from our colleagues on the phone?

MEMBER SANCHEZ: Yeah. This is Eduardo. Can y'all hear me?

CO-CHAIR PONCE: Yes, we can.

MEMBER SANCHEZ: Okay, thanks. I

wonder if there isn't some value in thinking about, and I don't know that any measures exist necessarily, but back to CHNAs or any kind of community health reports. Some measurement of to whom that report is reported and to whom that report is accountable, and the degree to which the plan itself has it evolved and as it evolves following a report, has institutionalized, codified, integrated community member and organizational involvement.

CO-CHAIR PONCE: All right, thank you. Philip.

MEMBER ALBERTI: Just a follow-up on that. So we've at the AMC we've now read through I would say well over two or three hundred community health needs assessments. It's a lot of work to really begin to think of how to standardize. You know, it's part of the requirement (a) that institutions partner with public health experts as well as local community residents, to really understand kind of the depth of that partnership and the collaboration

requires maybe hundreds of hours of qualitative coding and phone calls.

It's a great idea. The reason that I didn't include it in the culture of equity in that it really only is something through which public health entities and not-for-profit hospitals are beholden to. So it might not impact all the kind of health care providing institutions.

There might be some way to think about it, but you know, we might also then think about Schedule H community benefit, community building. You know, there are different ways in which not-for-profit hospitals report their connections and their financial support for community health improvement activities.

I'm not sure that, you know, recommending a deep qualitative dive is the easy, smartest way to go.

MEMBER SANCHEZ: Yes, this is --

CO-CHAIR PONCE: Sorry. Eduardo, can you follow-up on that comment? Or is that Kevin?

MEMBER SANCHEZ: I heard my name.

CO-CHAIR PONCE: Well, I just thought you might have, you know, you might have -- you might retort back.

MEMBER SANCHEZ: Well so despite that, I guess I would say part of what we've talked about is person-centeredness. Part of what we've talked about in terms of disparities is community centeredness, and until and unless there is some sort of accountability relationship that exists between the persons who are the persons and/or communities that are experiencing disparities and their ability to engage in the conversations about how to go about addressing those and how to bring perspective to that conversation, I think that we won't get as far as we could.

We can continue making this about we'll do a report and we'll pretend that we are listening and we'll do what we can, and I live in a community where there's lots of that going on, or we can try to figure out how we engage people and actually, as part of our exercise, recommend

that the degree to which -- and I don't know what that measure is to CF, the degree to which there is an audience and/or accountability to community, and that can be defined in lots of different ways. We should explore that opportunity.

CO-CHAIR PONCE: So I don't know enough about the CHNAs. I know we provide data to hospitals, but I'm not sure who has the authority to dictate the content of the CHNAs. Philip, looks like he knows the answer.

MEMBER ALBERTI: So a little. I do, okay. So to dictate what's in there. So the CHNA process is really kind of a tri-partite thing. So first you have to work with these local experts and community residents to identify and prioritize local community health needs, and that's done through primary data collection, surveys, focus groups, interviews, secondary data analysis of public health, vital stats, EHR data, whatever it might be.

Then through some other -- and the

folks that have leadership over that process is completely different from institution to institution. So it sometimes lives in the community benefit office or in the government relations department or in family medicine, and it could be anywhere. So there's no kind of set place.

Then the next step is to identify the prioritized needs that the institution will address and describe how, and what you expect the impact of that intervention to be, and then say which health needs you are not going to address and why, and it could be they don't have the resources, the hospital across the street is taking care of that, whatever it might be, and then develop an evaluation plan and you do that cycle every three years.

The requirement is that the CHNA doc that prioritized needs and the methodology in how you arrive at that list is publicly available. There's no such requirement or expectation for the actual implementation strategy or the

interventions, to find those which is really where the rubber hits the road so you learn kind of what the investment is and what the programs are.

That requires phone calls, emails, trying to really pull some of that information. It's not as kind of widely disseminated as the prioritized need. And the IRS is the body that reviews the CHNA and all of their community health expertise. The IRS kind of decides whether or not the institution is compliant with the regulation, and it's separate from community benefit and community building.

CO-CHAIR PONCE: Thank you. I think we have to have some more thought about -- oh, there's more. So Bob and Emilio.

MEMBER RAUNER: At the risk of getting in trouble, I'll use contrasting hospitals in our community who one, I think takes their -- has historically taken the community health needs assessment pretty seriously. They do interact with people. They do fund projects outside of

themselves.

They actually, I think, take it fairly seriously and that's also probably because the leadership, it's the director of nursing who is at the last community health improvement plan meeting, for example. They were very engaged and offered input.

The other hospital was the executive who told me this is a checkbox on our Form 990 and it's the marketing and development people that show up to the meetings, who have no background in this. They have what looks like a nice thing on their website, but I know in reality there's no dollars and there's risk. It's a checkbox on your 990. They paid for somebody to write a plan for them essentially is what they did so --

CO-CHAIR PONCE: Emilio.

MEMBER CARRILLO: I just wanted to comment on what Philip said. The IRS 990 specifications are quite specific. I mean they really specify with a great deal of detail how

the reports are to be done. Now as you point out, people fill them out 100 different ways. But there are the requirements well specified.

CO-CHAIR PONCE: Okay, thank you. Now I understand CHNAs now. But I guess for the purpose of what NQF needs, they'll have to think come up with more precise language and how you will use the CHNA information, or how we can inform how to make CHNAs be more accountable to what we need. Ron please.

MEMBER COPELAND: Well, yeah. I would just say given all we just heard about how and why they're filled out, I mean that can be anything from the checkmark to something much more impactful. But if we think about this in the context of accountability, then the question is not so much have you done the assessment but what are you going to do with the findings and can you demonstrate some commitment, either in your strategic business plan or whatever business document you use to guide resource allocation and performance. Can you -- do you have an action

plan and can you talk about some form of impact measurement over time in that action plan?

So that's -- the accountability question is going beyond the compliance requirement to do the assessment. It's then what do you with the findings that's going to improve health for a community or eliminate disparities or whatever. So I think if we're going to use the CHNAs as part of this, the accountability has much to do with it.

CO-CHAIR PONCE: Okay. I think somebody on the line wanted to chime in.

MEMBER FISCELLA: Yeah. This is Kevin. Yeah. I agree. I think that the measures should focus on the action part of the plan and the impact, and this is a way, I think, to really conduct community-wide interventions. Many of the existing measures here are really individual levels like, you know, at the patient level addressing social determinants and linking them to community health workers, etcetera.

But this is an opportunity for systems

to really engage in community-wide interventions, whether it's promoting, you know, physical activity or implementing diabetes prevention programs or childhood obesity, violence, whatever, or whatever the community health needs assessment shows.

So I think as long as -- we don't need to have all the details of the community health assessment, as long as we focus on actionability and ask that they reference that and they have supporting documents for why they chose that as a priority, referencing back to that community health needs assessment.

CO-CHAIR PONCE: Okay, thank you. So we move on?

MEMBER SCHOLLE: Hi, it's Sarah. I have a couple of comments.

CO-CHAIR PONCE: Oh. Go ahead, Sarah. Sorry.

MEMBER SCHOLLE: Yeah. A couple of things. The point is I think this conversation is really interesting, and I agreed with one of

the previous speakers who said all these domains seem to be interrelated, or some of them seem interrelated. There are several domains that are really addressing structure, structure for collaboration, structure for culture and there's some foundational components of that.

In our experience, actually measuring this becomes very tricky given the whole variety of situations that organizations are in, and in particular since in this conversation it feels like we've been ranging, I believe intentionally ranging from the idea of individual clinicians or practices up to large organizations like health plans, health systems or hospitals.

And so the capability of doing things really varies. Also, we have some organizations that are not-for-profit and do have a commitment and responsibility already, and then we have other organizations that don't have that like small physician-owned practices as well as larger for-profit institutions.

So the flexibility for being able to

address these issues in a way that doesn't -- that allows each organization to think about well what could I do on that continuum of work is something we may want to consider.

As we've developed standards for health plans and for practices, we've often had to struggle with how specifically where we're talking about structure where some organizations will come up with something that we hadn't envisioned and that doesn't actually meet what we said.

So that is really kind of a caution about thinking about specifically where to go, unless we're thinking of a specific implementation and opportunity.

CO-CHAIR PONCE: Thanks, Sarah. I think you've raised the question that we have. I think the next job for the Committee --

MS. O'ROURKE: To close that out. So I think we've covered most of the questions we've had up on the slide. So I think yeah, we could return to Sarah. We're just bringing up your

slides in the room, Sarah.

MEMBER SCHOLLE: It's good morning here in Anchorage, but I'm real happy to have a chance to review about some work that we've done that's sponsored by the National Academy of Medicine's Health Literacy Work Group, and they have put together a framework for integrating quality measurement across the areas of health diversity, language access and cultural competency.

If you'd got to the next slide. I have a delay in my slides, here we go. So it's interesting. So this was -- came out of the committee that focused on health literacy, and they asked us to think about how does that fit with cultural competence and language access. So our team at NCQA that includes Jessica Briefer French. You saw her name on this, because she was the lead author, and as well as Judy Ng and myself.

We started off by looking at the definitions of these three topic areas of health

literacy, cultural competence and language access. We looked at where they came from and we sought out some authoritative sources that defined the components of these areas, and then we also looked at existing performance measures that were available and to see how they tracked against these topic areas.

I don't think I need to define these terms for you, but it is interesting that these -- they're different constituencies and different origins of each of these topic areas, and but if we go to the next slide, as we look more deeply at the components of what's been captured in those authoritative sources, we see a lot of commonality.

Some of these sources include materials from HHS, the HHS Office of Minority Health and the Joint Principles for Patient-Centered Medical Homes and other definitions of patient-centered care. As many of you know, the recent update of the HHS Office of Minority Health cost standards specifically used a more

inclusive terminology to include health literacy, cultural competence, communication and language assistance, as well as --

And this -- so it broadened the perspective on the previous standards. We used the term patient-centered care because in many areas where we work, we see person-centered care/patient-centered care as also combining an interest and focus on these different topics. So Marshall, we presented these at a roundtable maybe last month, and Marshall attended and I think others were maybe aware of this.

You can see there's a lot of commonality with the kinds of domains that we talked about today in our work for this Committee.

So if we go to the next slide, so we were asked to think about how do these domains fit together, and you can see they really do capture many of the -- they address many of the same issues. They look at quality measurement and improvement should be directed at health

literacy, it should address cultural competence.

So we looked to see what structural measures existed that address these topics, and when we looked to available structural measures, we found a couple that are based on survey, including the Communication Climate Assessment Tool, which was developed by the ANA Group that is now stewarded by the University of Colorado I believe, and then RAND, who developed a cultural competence survey that was based on best practices that were identified by the NQF Committee.

Both of those tools actually depend on the survey. The interesting thing about the Communication Climate Assessment Tool is that in our two surveys, that is the survey from the perspective of staff and clinicians who work in the health care organization, and then it has survey for patients.

Our understanding is that that is used by some organizations for quality improvement. We're not aware that the RAND survey is used.

It's a single respondent from an institution. But the other way that we see these concepts being incorporated is through --

CO-CHAIR PONCE: Sarah, could you please speak up? I know you have a hoarse throat. Would you try to move closer to the mic? Thank you.

MEMBER SCHOLLE: Oh okay. Is that better?

CO-CHAIR PONCE: Much better.

MEMBER SCHOLLE: Can you hear me better now? Okay. So there are programs in place that are accreditation programs, recognition programs or even from the Medicare, the new merit-based incentive payment program that have structural expectations for organizations, that capture many of these topics around QI and data collection and other areas.

And what we found is that among all of these data sources, the only two that really capture broadly health literacy, cultural competence, language needs, communication and

language assistance is really the Communication Climate Assessment Tool, and actually NCQA's 2017 Patient-Centered Medical Home standards have really captured that as, you know, just one after another. Do you do each of these things? Or questions of QI that address the topics in there.

So I think what's interesting about this is that many of the areas that this Committee's been discussing this morning fit into this type of survey, that would be captured on behalf of the organization or reported by its staff or patients, or accreditation or recognition programs where the MIPS, these are the CQIAs, I think, the Clinical Quality Improvement Activities.

These are really conditions for participation rather than performance measures. So they're not reported individually for a number of people are who are eligible. It's more about does this organization have this capacity and can they demonstrate that they're actually using it? So you could look at numerators and denominators,

but it might not be for all eligible events the way we think about performance measures.

Okay, next slide please. So we look at process measures and really found very few that were specifically tailored to the topic areas of interest here. There's a suite of measures that are -- look at language services that G.W. developed. These are no longer -- I believe they're no longer stewarded and we weren't able to find that they are used. We've found there's one measure about TTY services interpretation that's in the famous Stars program.

But otherwise, measures that specifically address these topics we didn't find in the process realm, except if we go to the next slide, then we look at outcome measures like patient experiences, and this is where we've actually through previous work that we did for CMS, the same as Office of Minority Health, we catalogued the topic areas that are captured in existing patient surveys.

If we look at the domains of the CAHPS supplemental items, you can see that there are -- there's actually three supplemental survey data sets from the CAHPS, that the CAHPS team has developed. One addressing cultural competence, another health literacy the patient-centered medical home, and these capture some of the areas including discrimination, trust are domains in the culture competence measure set.

And then health literacy is captured, communication. I think it's communication broadly speaking. So but we were unable to see where any of the cultural competence items are actually used in existing national programs and health literacy I think, medication items are used in the hospital CAHPS, and I believe they might be used in the Medicare Advantage CAHPS.

So there's -- so if we go to the next slide, you know, in summary, we found that different groups have articulated the need for focusing on issues of health literacy, culture competence, communication and language support,

and what we find is that there are existing structure measures. They're not comprehensive. They need to be updated. They don't always take into account the broad range of topics.

But they are available as measures that can help to build capacity. It seems like there is a tremendous opportunity to think about how to use the existing items that have been developed to capture patient experiences. But our own sense of this world is that people want much more streamlined patient survey tools, not longer ones and there's really true concern that our method of capturing data on patient experiences today is based on -- primarily on mail surveys and may not represent the population that we're most concerned about, you know, in our work today.

We have heard consistently from stakeholders that there's a need to focus on a core set of measures and to work with what we have to stratify the existing quality measures, to focus, target improvement and we think there

might be an opportunity to really think about how we could develop packages of measures for vulnerable subpopulations, that might be a way for organizations to target concerns.

We've done this at NCQA. We've just developed a set of standards for long-term services and supports that becomes a required module for health plans when they have responsibility for that benefit. So thinking about if an organization has responsibility for a population, is there a package of measures.

So I offer this as work we did for the National Academy of Medicine, but I offer these ideas as strategies that the panel may want to consider in our deliberations.

MS. O'ROURKE: Thank you so Sarah. We wanted to have Sarah highlight some of the work that she's been doing, since it had so many synergies with the work of this Committee. So do we have a few minutes in case anyone has questions for Sarah? If not, should we move on and change gears a little bit, and start to think

about developing some of the implementation and policy recommendations?

(Off mic comment.)

CO-CHAIR CHIN: So Sarah, I was just saying that you get a gold star for participating at 4:00 a.m. Alaska time, so thank you very much and there was a lot of overlapping ideas with the NCQA work. So I think that these products can be mutually learned from each other, so that's great.

So in terms of where we're at, that so this morning that I think there was general agreement that the five equity domains for the consensual framework are in ballpark, and that seemed to work. People came up with some example ideas of measure concepts that might fill in some of the gaps, although I don't think anyone sort of entered that exercise thinking that their responsibility was to try to be comprehensive and figuring everything out in terms of each of those domains. So in some ways the report should probably reflect that it's not designed to be

like this the end-all, be-all, but more designed to give examples and help spur the field.

And so now we're going to turn to this issue of use of measures and so now we're in the afternoon. It's almost like 1:45, and here though I think we need to be alert, because this is really the opportunity that like harkens back to what Michelle said about like well, you know, we want the work to be meaningful and to have an impact.

It heightened back to what Christie said about well, this has got to be a business case to motivate people. It harkened back to what Ron said about road maps are great, and I think actually the road map we're coming up with is a nice model. But I think the way he put it was that road maps, if they're not used, then they don't -- they don't have an impact.

And so really this particular part where you talk about now use of the measures is we're looking basically to make sure it has an impact. When you think about it too, like with

the overall work of this Committee, the part that we have most -- the biggest worry we had is this discussion, because the vast majority of the final report are going to be the Committee's recommendations to CMS and others about well, what to do with all this, and again this is the opportunity that we have not had before.

And so we're actually going to be sort of brainstorming this afternoon, that it's sort of a big area. And so -- and what's going to happen is that Drew and Erin and the team are going to tonight then make things a little more orderly in terms of like then coming back to us in the morning, sort of like what happened last time.

So don't worry too much about having everything sort of fit cleanly and nicely and all, and so that basically we want to get the ideas out there and then we'll have a chance to revisit tomorrow morning. And so we're going to start first with Drew's going to talk a little bit about some existing efforts by NAM and ASPE

that help provide a little bit of a framework, that I think we'll sort of go beyond it.

But like at least it provides a starting point for some of these ideas, so that we can make our discussion a little more efficient. Then we'll go into the -- on the agenda it's like three different sessions on different topics. In practice, we'll going to meld together. So it would be much like there being like three discrete areas.

The three different general topics were how do we leverage existing quality initiatives. So lot of issues in terms of guidance on data and scoring, and then guidance on incentivizing the reduction of disparities. But in practice, this is going to morph together probably, and there are some guides in terms of the bullets.

But again, we don't need to be too wed to them in that like I think it's all going to morph together. But I think it will work out fine, I think. But we need to be in sort of

brainstorming mode, high energy and I'd also say don't -- we shouldn't constrain ourselves artificially, that we should put on the table whatever we think is going to be effective reducing disparities, and whatever constraints or other issues that are involved, that really is not our concern right now.

I'll try to come up with a road map of what we think is going to be most effective. Some which may be implemented in the short term, some of it may end up down the road. But I don't think we should have artificial constraints to what we do. So I'll turn it over to Drew.

DR. ANDERSON: So I'm just going to briefly run through the NAM recommendations and ASPE recommendations that was included in the meeting materials, and I'm sure you all are familiar with this at this point. But we wanted to just set the stage for the recommendations that you're about to discuss in this section.

So as far as the NAM recommendations, they recommended first that social risk factors

be looked at in these four different ways. So they should be basically looked at, identifying these methods of stratifying for public reporting. I feel like my mic keeps going in and out, and for patient characteristics, adjusting performance measure scores, direct adjustment if actual payment and restructuring of payment incentive design.

So these are kind of the line-up with some of the recommendations that we already have in the measurement framework. To achieve these goals NAM -- the committee recommended that measures be adjusted, measure scores be adjusted for social risk factors while also including the stratified data within reporting units.

Just breaking that out a little bit more, I won't go through each one of these individual examples, but they provided these essentially use cases for how to apply these four different ways or methods of looking at social risk factors.

So then jumping ahead to ASPE's

recommendations, so you all are familiar with these three big buckets. Essentially the first is to measure and report on quality for beneficiaries, so looking at Medicare beneficiaries. The second is setting high and fair quality standards, and then the third was rewarding and supporting better outcomes.

And so within each of these three big buckets, there were several considerations that ASPE laid out. The first was to enhance data collection and develop statistical techniques to allow measurement and reporting of performance for beneficiaries with social risk, and then the second was to introduce health equity measures or domains into existing payment programs, to move measure disparities and incentivize and focus on reducing them.

And then the third consideration under Strategy 1 is to monitor the financial impact on Medicare payment programs on providers disproportionately serving beneficiaries with social risk.

The second strategy setting high and fair quality standards for all beneficiaries was the first consideration is that measures should be examined to determine if risk adjustment for social risk factors is appropriate, and then the second consideration really focused on whether better adjustment for health status might improve the ability to differentiate true differences in performance between providers.

And then lastly, the third strategy was rewarding and supporting better outcomes for beneficiaries with social risk factors. So the first consideration was considering to create targeted financial incentives within value-based purchasing programs, to reward achievement of high quality and good outcomes. The second consideration looked at using new or existing improvement programs to provide targeted support and technical assistance to providers that serve beneficiaries with social risk.

And then the third was developing demonstrations or models focused on care

innovations. So this is similar to the last recommendation that's already a part of the measurement framework. And then the last, fourth consideration was considering further research to examine the costs of achieving good outcomes for beneficiaries with social risk factors.

So that brings us back to the fourth step of the measurement framework, where we included these five recommendations that we have from this committee, and during the break, we were talking a little bit about which ones we would probably need to focus a little bit more time on.

And so this first one of incorporating equity measures into payment and reporting programs, we would need to get some more detail on what would look like, and existing safety net providers is another one, and a third one is looking at conducting and funding demonstration projects. But we can walk through these step-wise and we can just start the discussion, start throwing out some ideas. But I'll turn it over

to Marshall to lead the discussion.

CO-CHAIR CHIN: Yeah. This particular slide, like two of them are fast. So like aligning equity across payers this in some ways what NQF tries to do anyway. The one about demo programs, well demo programs are sort of part and parcel of things. Sort 1, 3 and 4, the ones which are the ones that need to be drilled down on.

One is a big one. The third one, in terms of social determinants of health and preventive care is a big one. Safety net organizations is another big one, where some of them are like the others, but there are special issues for safety net also, so pretty complicated.

Just a couple of points. Again, that NAM meeting yesterday that it was like David and Philip and Ninez and Nancy and Christie were there, and Lisa. So a lot of people were there. So this is great, and Helen was there. I mention that over half of the discussion I believe was on

the reputed topic of the day, which was the social risk factor adjustment. But was on essentially the stuff we'll be talking about this afternoon. So they sort of saw that it was important, critical to address.

The other thing that was striking was at the end of the day, there's this issue of what happens next. Well, the NAM, they have a very contracted basis, so that they're not doing further work in this area per se. There is the Department of Health and Human Services, assist the Secretary for Planning and Evaluation.

So they are continuing to do some work, so they're sort of one of the factors that are involved. But there aren't necessarily other groups that are really sort of plowing ahead with this. So again, we have an important role potentially in terms of like just keeping the momentum going.

So when we start then with the brainstorming, Tara's going to be recording this in a real time so everybody can sort of follow

along in terms of the brainstorming that exists. But maybe the place to start is like if you look at the 12:45 agenda item, the second and third bullets, there's two general questions. I'll start things going.

What are the existing programs, tools, policies, etcetera that can be leveraged to incentivize the use of measures in this area, and then very generally also how can equity measures be incorporated into existing CMS programs. If we start with those two, we'll probably get a general template out there that we can start following with the other bullets and drill down on the questions.

So numbers 1 and 2 then. Actually, numbers -- yeah, numbers 1 and 2 up there, yeah. Start ahead, Bob.

MEMBER RAUNER: And maybe this is just redundant, but out of those first two, I think the big one comes down to there's the measures are already in use by HRSA, by CMS. It's the biggest thing is stratification because that data

just isn't there, although it actually is most of the time in the EHR. It's just not in the claims data, and that's I think our big obstacle.

A lot of FQHCs have meaningful use compliant EHRs, where you can pull about ethnicity, by language preference, all that in. It's just that it's in their EHR which doesn't -- - isn't brought in centrally. I think the big challenge is bringing in that -- the social factors that can adjust for this, because if we could adjust for that, we can prevent the harm.

And that's -- for me, that's the single biggest priority, is adjusting our currently used input measures for this type of stuff along those lines, and that's our big obstacle.

CO-CHAIR CHIN: Two things there, Bob. So one is to use the existing programs, the various existing value-based programs as well as some HRSA programs, and then you also applied two different things.

One is the social risk factor

adjustment issue, which we'll talk about I guess tomorrow afternoon in terms of the trial period, and then the other thing I heard was well then stratifying by social risk factors for a variety of purposes. So we have -- is that Emilio out there? Yep, Emilio. Emilio, you're up. Oh sorry. Or we'll do Ignatius and then Michelle and circle back to Emilio, and then Nancy.

MR. BAU: So the way I would answer is that unfortunately it does go back to payers, that I think within Medicare --

(Off mic comment.)

CO-CHAIR CHIN: We thought you were a deep thinker.

(Laughter.)

CO-CHAIR CHIN: So we'll do a dramatic effect.

(Off mic comments.)

MR. BAU: So in Medicare, CMS has done a lot obviously with Accountable Care, with Comprehensive Primary Care Plus, lots of initiatives that are trying to do value-based

purchasing and outcomes, but hasn't had an explicit focus on equity. So again, could CMS in some of those Medicare innovation programs design something specifically to incentivize the reduction of disparities and the achievement of equity?

The other, as many people have noted though, the disparities population is more likely though in the Medicaid population, and again it's obviously problematic now with all the politics around Medicaid. But if there were ways that CMS could also leverage the Medicaid program, again to specifically call for state innovation grants that weren't just about value-based purchasing, but actually about the reduction, the explicit reduction of equity as part of innovation.

And again, there may be a way to structure CMS or ACA Section 1332 waiver around that, which is as long as you don't increase costs, you can do some additional things with Medicaid within the state. And then on the commercial side, back to the California example

which is that covered California as a state insurance marketplace is now placing explicit requirements on the qualified health plans within the exchange to not only improve quality but also make progress on equity.

So that's again an example that I doubt the federal marketplace ever will do, because it's having problems just keeping plans in. But that would be a strategy as well.

CO-CHAIR CHIN: Thank you, Ignatius. We have Michelle and Nancy.

MEMBER CABRERA: Well, I think one of my biggest pleas on sort of how we think about crafting policies to make sure that as we're aligning across different purchasers, that the alignment doesn't drop this issue. So we have to think about strategies to make sure that that doesn't happen, like you know, even as simple as talking about Quadruple Aims that includes health equity instead of just Triple Aims, right. So stuff like that.

Everything that Ignatius just said

plus I have a crazy idea I wanted to throw out, which is for NQF's work, I know there was really good conversation around SDS risk adjustment that centered around an agreement, it seems, that there are certain quality measures that in no case should be adjusted, because there is no -- absolutely no connection whatsoever to SDS, right.

Like you leave a sponge in a body, that's on you, right. Like nobody can blame that on anything else. So can we pull out those measures that are known that we can agree to and say these are the things that have absolutely no relationship to SDS, and then leave everything else in the we don't know yet category, right? Or with explicit caveats where we may know that there may be a relationship to disparities, either in how it's applied.

So warning policymaker or payer, you may want to be careful about how you apply this measure, because it could in fact have unintended consequences on certain subpopulations or

something. Like I'm trying to think of how to get, how to engage people in a conversation around the actual measures, and what we know about their relationship to disparities.

Because I feel like we're going to have this conversation tomorrow about the trial period, and I understand that's different. But this is sort of the -- in my view measures are policies, you know. There is a policy angle to any measure because we're not developing them for the sake of developing them. We're developing them for the sake of creating some sort of change. I think this is sort of a filter that can be applied to all of NQF's measures.

CO-CHAIR CHIN: Thanks, Michelle. We'll do Nancy, and then rotate to whoever on the phone wants to comment, and then we'll take back up to the in person panel.

MEMBER GARRETT: So I'm going to take your prerogative to not have limits here on the conversation, and just say I'm not sure that the question is quite broad enough. So I would say

our question that we should really consider is what existing programs, tools, policies can be leveraged to incentivize disparities reduction? And so that's even a little bit bigger, but use of measures feels a little bit limiting to me.

And so an example is the -- in the NAM report, one of their four methods for kind of for social risk factors is direct adjustment of payments, and so how might that be done? Well, a payer like Medicare could look at what are the vulnerable populations where we know that there's going to be additional resources needed and how do we have some payment enhancements for that.

One of the quickest places to change is in some of the models, especially like the ACO models. That could be a place where some of this could start. But it doesn't have to be. It could also be a fee for service kind of payment enhancement that's looked at. There is some work going on in Minnesota with our state ACO through our state Medicaid agency, where they've just proposed a new model, where there will be some

additional payment enhancement for population for social risk factors in an upfront payment if you participate in the model.

So there's, you know, specific policy work that you can do within those models that can be a little bit faster. The one thing I just wanted to bring up from the conversation yesterday was my favorite quote of the day, was one of the -- I think it was the person from Boston University who was talking about some work that was done on the original ACC model as well as some work with another.

He said there's a precedent for overriding what the data wants to tell you, and so basically he was saying if you do empirical models and you find out that the factor that you really want to incent and have more resources going to that particular factor, if it doesn't come out in your model as significant and you have sort of a policy reason to do it, you can still weight that variable in a different way.

I thought that was really helpful and

something we need to think about, especially with something like trying to figure out, you know, a payment enhancements or additional resources needed because the data is not there. I mean it's not -- a lot of the resources that are going to those populations right now, there's no reimbursement for it so it's not in the claims data.

So if you do a model, you're not going to find what that resource should be. You're going to have to come up with another way to find it.

CO-CHAIR CHIN: Thanks Nancy, and that's one of the issues that we're going to come back with, right. Once we have the menu options of out there, there may be some that may be appropriate in certain situations, more appropriate in certain situations for certain goals.

So for example, one thing that came up yesterday was this issue of like -- of a safety net just being so under-resourced that you might

need to have a variety of different ways to sort of fill in that gap. So it's one example. So next, anyone on the call? Now's your first chance to jump in. So anyone on the call want to comment?

MEMBER BERNHEIM: This is Susannah. Go ahead Kevin.

CO-CHAIR CHIN: Go ahead, Susannah, then Kevin.

MEMBER BERNHEIM: So I want to defer to you guys about when to bring this up, but I had mentioned to you and Ninez that there's two things that CMS has actually put in their rule this year related to this topic, and I wanted to make sure the community was aware. So you tell me. Is this a good time to bring that up or should we get to it later?

CO-CHAIR CHIN: I think it's fine, yeah. Go ahead, Susannah.

MEMBER BERNHEIM: It relates to this concept that -- part of why I thought of it is that it relates to the concept that Nancy brought

up. So CMS put out their proposed ICPS rules, a rule that relates to hospital payment but also quality programs, and they will put a final rule out in August. So all of this is just in the sort of out for comment. Actually, the comment period just ended.

And one is, and I mentioned this before, but the Cures Act specifically did exactly what Nancy just said, which is it changed payment policy. So CMS now has said how they're going to enact that. So this is in the context of the hospital readmission reduction program. CMS has proposed the approach they're going to take to stratify hospitals into groups.

So not patient-level stratification, but put hospitals into different groups based on the proportion of patients that a hospital serves that are dual-eligible, and then leave the readmission measures untouched. But after those are calculated, they will set different payment thresholds for hospitals on the basis of the hospital's proportion of dual-eligible patients.

So this is a, I think in that sort of fourth mechanism, which is sort of directly affecting payment adjustments based on a hospital's case mix. So I wanted to make sure people knew. I don't actually remember when they're proposing to put this into place. There's a lot of details about exactly how they do the calculation and set the thresholds.

But just as a high level concept important for this committee to know that CMS has made a next step on that.

The second reason, I think this will get way too in the weeds, so I'm going to stay very high level, but happy to talk about it some more as I'm thinking about it is we worked with CMS and they have put out not even a proposal, just sort of a signal like what do people think of this. But the signal was to include in reporting eventually, but initially just privately report to hospitals mortality and readmission rates when you get your overall mortality and readmission, but you also get an

indicator of within hospital disparities in your mortality and readmission rates, again using dual-eligible as a factor.

We could talk endlessly about what the right factor is, but essentially ASPE's report said dual-eligible is one of the most feasible of the things Medicare has, so that's where they're starting. So this would give an overall score.

You know, your pneumonia readmission rate is this, and then it would give an indicator of the difference in the pneumonia readmission rates for your dual-eligible versus non-dual eligibles who are included in that measure, and that indicator obviously varies across hospitals.

So there's some hospitals that have very close rates between the two, and some that have more much more distant rates. The statistics of this were complicated for us because the outcome measures have to be case mix-adjusted. So we didn't want to come up with a disparities indicator that basically said your dual-eligible patients are sicker than your non-

dual-eligible patients.

So we had to do it in the context of a model that also kept the case mix adjustment constant for the two groups. So that's what they -- they didn't even propose. They sort of, they said we're thinking about doing this and we're seeking comment on that.

And so that is also in the rule, but also I've seen CMS take the step towards inequity measures. So I wanted to make sure the group was aware that both of those things were in proposals from CMS right now.

CO-CHAIR CHIN: Thanks very much Susannah, and stratification is a big topic we'll need to come back to, because it there's a lot of complicated things that are really important. The actual NAM report, like their recommendation was to use social risk factor adjustment when appropriate and then also they said you need to also then report stratified data as one of the work-arounds to make sure you don't mask disparities or explain them away. So that's one

example.

In Susannah's first example, it raises like one approach for trying to deal with some of the problems. So like this issue of like well, if you have like some type of absolute threshold for performance, well the hospitals that take care of more difficult populations are disadvantaged compared to the more advantaged populations.

So they -- they have sort of like decile issue where you're compared to hospitals with a similar decile as you. So comparing like with like, so that in a healthy program, you'd have then the penless hospitals spread out across these deciles as opposed to just putting them on the safety net, as one example. Which raises other issues.

But so stratification I'm going to come back to. How it also relates is an issue too because it's something that these committees at NQF has also sort of grappled with, is some more clarity about how we think about

stratification would be useful. So we'll definitely come back to this, because it's a big one. Kevin.

MEMBER FISCELLA: I agree with what Nancy was saying, that we want to -- I think measures are an important part, but we don't want to necessarily start with measures and then look a little more broadly and then think about how measurement can be integrated and then to -- into thinking more broadly.

You know, the other example is -- is really the out of pocket costs and value-based design, you know, where evidence-based procedures and drugs have much lower out of pocket costs, co-payments.

And, you know, that could even be extended as, you know, some employers do to, you know, reducing those -- those co-payments based on, you know, employee job category or income or what have you. But that would be another, another lever that is not really necessarily measurement-based, although measurement could

play a role in looking at it.

CO-CHAIR CHIN: Thanks, Kevin. Anyone else on the phone before we go back to Bob?

MEMBER SCHOLLE: Hi, it's Sarah. I just wanted to suggest that in the programs for Medicare Advantage and for like the CPC, the shared savings programs for ACOs, that there's an opportunity to put more teeth and the MIPS program. There's some opportunity to put some more teeth into expectations about having complete data on the accuracy and completeness of the data about social risk needs, and about how that's used and the quality improvement, and so that could be drawn on by --

There are pieces in the Joint Commission Accreditation for Hospitals, there are pieces in NCQA's programs for different kinds of entities, where by calling on those -- calling on organizations to actually meet the existing standards, would be a way for CMS to move that and also to make some requirements in programs like MIPS.

I think somebody mentioned the special needs programs and their model of care, where those could be strengthened as well, to get as many of the structural kinds of topics we discussed this morning.

CO-CHAIR CHIN: Just to make sure I understood what you said there Sarah, so one, you meant like having some measure of like -- or basically for reporting programs, somehow rewarding them better data collection of social risk factors as one. Then the second you mentioned was quality improvement, and I didn't quite see what you meant there.

MEMBER SCHOLLE: So where organizations as part of participation would be able to participate in a program would need to demonstrate that they're actually working to reduce disparities in their population, that they not only know about the social risk of their population but they're actually -- they've identified areas where they can target their quality improvement on equity.

CO-CHAIR CHIN: Great.

MEMBER SCHOLLE: And those types of expectations already exist in some of the accreditation programs or they can be added that way.

CO-CHAIR CHIN: Thanks, Sarah. Anyone else on the phone before going to Bob, Lisa Iezzoni, then David and Emilio?

(No response.)

CO-CHAIR CHIN: Okay, Bob.

MEMBER RAUNER: Can I just talk a little bit about Michelle's idea of having the STS measures noted in categories? You know, somewhere it just shouldn't like the sponge in the body, and the other extreme being where we know some measures really do have a strong component, like what David said on the A1c and blood pressure control and colorectal cancer screening.

There's pretty good evidence that those should be. Then you have really I think one or two middle categories. There's somewhere

is a conceptual basis, but the evidence doesn't support it like A1c testing. That's a pretty close cross. And then there's the category of sort of unknown and mixed, like I think some of the hospital readmission measures have mixed results.

I think part of the problem is because they're not using patient level data. They're using zip code or something like that and that's probably clouding the data a little bit. So I think it might be good to start putting those in categories, just like with all kinds of medical recommendations.

You have levels of evidence A, B, C, D, you know, that kind of thing, that maybe we should list that so that if somebody like a payer is going to pick a measure and it's something that's relevant like colorectal cancer screening, they really should listen to somebody when they say no, this FQHC should be adjusted and paid differently because of this, because the evidence is out there and we've already got some of it.

So --

CO-CHAIR CHIN: Thanks Bob. So we have Lisa Iezzoni, David, Emilio, Michelle.

MEMBER IEZZONI: My apologies for ducking out of the room. I hope I'm not repeating something that somebody's already said. Marshall, you challenged us to think out of the box. I'm from Massachusetts. I have an example that I think is kind of out of the box.

I know that many of the people we're talking about today have chaotic lives and kind of organizing around quality measurement in their health care is not a priority for them. But in Massachusetts when the One Care program was designed, and for those of you who don't know, this was the Medicare/Medicaid demonstration program for dually eligible individuals ages 21 to 64.

So every single one of these people was eligible for Medicare because of disability. The local disability community was at the table, and the advocates were very, very involved. And

so I know we have talked about other constituencies, but we haven't really talked about advocates and people who have these disparities conditions.

So let me just give you the one example that I think is just so telling, the One Care program is dually capitated, and during the first year the capitation payments were falling way short of what they needed to be, primarily around the beneficiaries with serious mental illness and substance use disorders. Their costs were just through the roof, and the state was literally about to pull out of the program.

But where Mary Lou Sutter, who is the secretary of the Executive Office of Health and Human Services, so Charlie Baker's health secretary, took two persons with disabilities, Dennis Heaphy, who's quadriplegic from a spinal cord injury and Olivia Richard, who is paraplegic, down to CMS and those two constituents talked in front of the CMS officials about what One Care had been doing for them, and

CMS raised the capitation rates.

And so you had consumers who directly saved the program, and Mary Lou Sutter talks about that. I know that that might be kind of an extraordinary example. But I think if you want to talk out of the box, that maybe we should start thinking about how can we engage the advocacy side of the consumer representatives.

CO-CHAIR CHIN: Thanks, Lisa. So we have David and Emilio and Michelle.

MEMBER NERENZ: Yeah thanks. Small point here, but I think maybe in a preface piece leading up to however this plays out in a report, it's probably worth noting that many or even all of the current P4P programs already in their current structure include incentives for disparities reduction by the entities being measured.

You know, this is a track we started on over 20 years ago when we worked with health plans on their HEDIS measures. If any given HEDIS measure within your plan you have groups

with disparate rates, one way to get the overall rate up is to get rid of the disparity. Now of course it's also mathematically true that you can take the advantaged group and bring that down. Then your disparity is gone, but people don't typically do that.

But we typically don't talk about that, and it's not quite in line with the phrase "leverage." But I think it's worth just noting they're both for our own -- in our own heads in whatever document we write, because in the 20 years that have gone by since I started working with plans on this, the incentive has not gone away.

It's still there, and whether it's your hospital, whether your clinic, whether you're an ACO, the incentive is still there. The user of the stratified data would be the entity being measured, and maybe that's why it doesn't quite rise to prominence. But I think it's still worth holding on to.

CO-CHAIR CHIN: Just a question for

you Dave, and maybe a question for the wider committee is the current system where basically you're trying to improve an aggregate number and Dave is right, that well if you do improve the numbers of the lowest-performing population, well that's going to help your aggregate number.

Is the kind of program that's designed you think adequate, or are there ways to tweak or supplement or changes that were more likely to lead to equity?

MEMBER NERENZ: Well, I'm trying to frame the comment to imply I didn't think it's adequate, because if I thought that, then with this whole list I'd just say forget about it. You don't need anything else.

But I don't want to imply that it's zero, because it may be active and driving improvement right now in ways that we probably don't see because it's sort of out there hidden in ongoing daily, you know, non-trumpeted key line activities. But it's worth noting. It's not zero.

CO-CHAIR CHIN: Thanks, David. So we have Emilio, Michelle. Emilio and Michelle.

MEMBER CARRILLO: In terms of measures, federal measures and others that have teeth, I think that we should focus on the NHMA, the benefits that are basically -- have a lot of teeth because, you know, the tax exemption for hospitals is tied to them. And I think that these measures could -- this could be a good leverage.

CO-CHAIR CHIN: So Michelle, then after Michelle I'm going to ask if the committee can specifically address the second bullet that we talked about, how can equity measures be incorporated into existing CMS programs, again just as a template for getting some of the general ideas out there. Michelle.

MEMBER CABRERA: This is restating, but it's because this isn't -- I don't think yet on the list here. It came up earlier in conversation, but I do think it's important in terms of policy levers, to make sure that we are

targeting our conversation to different payers or large purchasers. So that's one piece I want to make sure is in there.

Obviously, I mean I think anything NQF and other groups can do to kind of join together across the quality and measurement community, now that there's so much synergy, to kind of like maybe create a joint call to action or a joint initiative, urging people to actually collect the damn data, you know.

That would be good. We could try something like that. Collect the damn data. But you know I think that we've all been clear that like that's a major nonsensical stumbling block in all of this. I think that's all I have.

CO-CHAIR CHIN: Some of the things we might put into a parking lot of like -- some of these are implementation issues, some things you raised, some of Lisa's points also that we should at some point come back to. Let's let Helen jump in -- okay. Okay, so you're now third. So Philip and Lisa, and people start to transition

it into this bullet about how can equity measures be incorporated into existing programs.

MEMBER ALBERTI: I'm not going to quite start that transition. So we were talking about this at the last meeting, I think, but another important lever is really the ACGME, kind of expectations that now exist around training residents and fellows around health care disparities and quality improvement.

So I think incorporating kind of that need and that stakeholder group into this conversation as other advocates. I know that they are thirsty for ideas on how to actually meet those expectations. Not many places are doing it well, and this could be a real opportunity to add some voices.

CO-CHAIR CHIN: Thanks, Philip. So Lisa Cooper and then Helen.

MEMBER COOPER: Okay. Mine will be quick, or I hope anyway. So well one -- both of them are actually questions, so I don't know what people are responding to, but I know at my

institution, someone came to me I honestly don't remember which organization was coming through to assess how well we were doing.

But there was all of a sudden a panic that we did need to have training for the residents, and how to address. So you think it was the ACGME? Okay, all right. So that just happened like, I don't know, about a couple of months ago. It was like this big panic. We've got to get this training in place. You know, it's like oh. Like I've been saying this like for a long time.

So anyway, so that. So it's good to know that, and then -- but my other question is almost is to David, like if these incentives have been in place for so long, what do you think is the missing factor? Like why is it that that hasn't risen to greater awareness or prominence or whatever? Like what -- is there anything that we haven't said already that could help to address whatever that missing link is?

MEMBER NERENZ: Well I guess, you

know, I'll give two types of answers. One is that, you know, there's a business case challenge, there's a how do you do it challenge, there's difficulty and people may try and not succeed challenge. Okay, there are a number of things. That would be a part of the answer.

But I guess the other thing I'll throw back to you, how do we know that people are not doing this? Do we know that people are not doing this already? Not just case -- but nationally as a pattern, do we know that people are not doing this?

MEMBER CABRERA: California is a largely managed care state. We've been asking this kind of stuff for years at these payer-purchaser tables. Some health plans are is the answer, and no one's asking them to do it as far as I can tell. They're doing it for I think your HEDIS kind of reasons.

But it's so -- it is so discrete. It is so not shared. So this is again California, lots of managed care plans and people doing this

stuff. But it's not, in no way getting discussed and it's not a set priority of whoever's paying. So whether it's the employer or the Medicaid program, they're not the ones asking for it. So we don't have a good handle.

We have anecdotal, a CEO of a MediCal managed care plan saying we did something on this once, but that's about it.

MEMBER NERENZ: Yeah. Well, I said it that way. I do it a little tongue in cheek. I'm intentionally trying to tweak us but, you know, a lot of these discussions seem to be based on the idea that health plans are doing nothing. We're totally ignorant and ACOs are doing nothing and they're totally ignorant. Hospitals are sitting around there and they don't know anything.

(Simultaneous speaking.)

MEMBER COOPER: Right, right, right. No, I don't think they're not doing anything. Well here's been my experience. They're -- the health equity people and the population health people are in completely different silos, and

although the health equity people can see the connection to the population health work that's going on, the population health people don't seem to see the connection to health equity.

So it's like how do we articulate that so that all these different siloed efforts come together and are more explicit about addressing this issue, because they're doing things but they're not doing them explicitly to address this problem.

MEMBER NERENZ: Yeah, and then I'll tweak and then I'll quit tweaking. Does it need to be explicit? You know, is that always the way you solve problems? Part of our thinking a while ago is if you go to work on improving quality and X measure, you know, you may -- you may need to explicitly focus on a disparity, but you may find yourself doing the right things and getting the right result and reducing the disparity, without having a so-called disparity person or an equity person ever touch it. So I'd just --

MEMBER COOPER: Well, the only thing

is that then -- well, this is not working, that you would -- then we'd then have to measure -- I mean the only way we'll know, even if it's not explicit, whether it's having its intended consequences is if there's some kind of measurement around that. Right now, there's not so --

MEMBER NERENZ: Well, who's the "we"?

MEMBER CABRERA: Can I just say that when you look at maternal infant mortality for African-Americans in California compared to everybody else, when you look at diabetic amputations, when you look at all these -- asthma rates, etcetera, like that is the impetus, right? What you measure on HEDIS and whether or not you're doing well on that report card certainly matters to a purchaser. Good for them.

The reason why we should have a disparities-focused conversation is for black people in California, because it is our responsibility to make sure that if there's something that can be fixed about that problem,

that we at least try.

CO-CHAIR CHIN: This is a great discussion here. So Helen and then Tom.

DR. BURSTIN: Just one point, and I apologize if I was out of the room trying to make the room warmer, and you mentioned this, that it's kind of freezing in here, but I wasn't sure where this would fit. But there's been a lot of discussion over the years that if we had more measures that reflected percent improvement or trajectory of improvement over threshold, that might be another pathway.

It's probably here. It doesn't fit in the other boxes I think. But I just don't want to lose sight of that, because I think, you know, it certainly is somebody's practice in the safety net. I can get somebody's A1c from 15 to 9, but I couldn't get him to eight without insurance, right? I mean it was just the reality of some of the practice, and being able to incentivize some of that might be really helpful.

CO-CHAIR CHIN: Yeah. That's a great

example of some issues that I think we need to get out over the next hour, that we can return to. That's a classic one, thresholds, absolute improvement, combinations and all. Tom.

MEMBER SEQUIST: So I have a bunch of different comments, but they're sort of interrelated to each other, sort of building on what Helen said, just said, more of a measurement concept question which was I think we should be clear about what the goal is that we're hoping to achieve.

We've been talking a lot about elimination of disparities. So that's a different concept and Marshall, you know well the RWJ work. You've fully aware of this. But that's a different concept than improving minority health. So you can have two populations who are one performs at ten percent, you know, the white group, and the other performs at five percent, the black group.

If you get the black group to ten percent, everyone's still getting crappy care,

and is that victory? Did we claim victory and sort put the flag in the ground, or are you actually trying to drive improvement to minority health? They're probably both important, but I'm just -- like we should just be clear when we're developing the measures or making recommendations, what it is that we're hoping to achieve.

That gets into your question, Helen, of are we trying to do percent improvement here? Because you're right. Like if you get the A1c from 13 to 8, you've really achieved something in everyone's eyes except -- and I'm not picking on NCQA, except like a HEDIS measure, in whose eyes you haven't achieved anything because you haven't gotten the measure that we're thinking about.

But you've -- so you wouldn't have improved your disparity measure if it was based on a HEDIS goal, but you have improved minority health. So I think just throughout all of these measures, we should be just more explicit about which goal we're hoping to achieve. Were you

going to say something or --

CO-CHAIR CHIN: Yes sir. So keep in mind Tom and Helen's combined point. Three different things that are different and related. Absolute thresholds, relative improvement, so that's improve minority health, and then disparity reduction, so actually think of black-white disparity reduction. All three are possibilities.

MEMBER SEQUIST: Yeah, and that disparity reduction statistically turns out just to be the hardest thing for us to achieve or to demonstrate that we've achieved. For the CMS programs, and so I was just looking at this -- at the second question that you wanted to start to get into Marshall, and I'm thinking we should be a little more clear about what we mean by existing CMS programs, and I'm sort of dividing this in two frames in my mind, and just to bounce this off of people.

So one is hospital versus ambulatory, and then the other is process versus outcome

measures. The problem with tagging on disparities measures or health equity to CMS programs that are in the hospital space right now is they're all popped off. So if my hospital performs at 97 percent for AMI, you know, hyphen whatever measure that we're -- and I promise I'm not trying to make fun of the NQF names for the measures.

But like if I'm at 96 percent on that, there are -- like just to David's point. There can't be a disparity that's not important, right, unless you have some crazy outlier hospital that just is, you know, and probably doesn't exist anymore for most of these measures. Most of those measures are topped out because they're quite old or they're process measures.

So that's different than CMS, newer CMS programs, ACO programs, MACRA, MIPS, APM, that are going to move into the ambulatory setting and are going to push us towards outcome measures. I feel like that's the area where you could get some real value we're trying to think

about building in equity measures.

I don't think -- I just don't think you're going to get a lot of value out of equity measures that focus on disparities and process measures, whether it be in the ambulatory space or the hospital space, because also hemoglobin A1c annual rates for diabetics are very, very high, regardless of the plan right now.

So the disparities that are going to be kind of not that -- even if they're there, they're going to be statistical phenomenon and not clinical phenomenon. But the A1c control rates like Helen is referring to or the blood pressure control rates or things like that, I actually think are going to be really important and I agree with what David is saying, which is that joining an ACO program --

So the fact if a health system joins an ACO program and an accountable care program, and you hold them accountable for outcomes measures, they will focus on disparities, because that is the only way that they will reduce trend

and improve outcomes, which is what these programs are holding them accountable to.

So I actually think, and I know you were sort of being devil's advocate or trying to prod us, but if you develop an accountable care program that focuses on outcomes, it will drive people to address disparities because they will have 20-30 percent of their patient population not achieving care goals, being readmitted a lot, you know, getting all kinds of complications in the ambulatory hospital setting, and they'll focus on it without an equity program.

But if you -- if you focus on process measures in the CMS program, and don't have an equity program, they won't focus on it because they don't need to, because the rates are so high and you don't need an equity program necessarily for most of those measures.

CO-CHAIR CHIN: Very helpful comments, Tom. Thank you. So I think it was Romana, Lisa Cooper, then Philip, then Nancy.

(Off mic comments.)

MS. MURPHY: So I have a lot of comments. I really appreciated everything that Tom said, and I agree with everything you said, except I -- I guess I do question the ACO's focus on outcome measures. They'll be focusing on equity measures or disparity measures. I think it's dependent on, you know, how the ACO, who is in the ACO.

MEMBER SEQUIST: Well, I should caveat at least (a), they'll focus on it if they want to succeed, and then (b), if they have the population, if they have the right population.

MS. MURPHY: That's exactly right, because I think there's, you know, I think Katarina Armstrong I think maybe wrote a really good piece about how ACOs have come together. I know there are some that, you know, that have populations, but a lot of them from my understanding, and I haven't looked at the literature in a while, just don't. So I just want to kind of raise that.

But I wanted to get back to Lisa's and

Dave's kind of discussion. So Lisa starting with, you know, population health people don't really necessarily talk to the equity people in the organization, and then Dave's comment about, you know, does it have -- Lisa saying, you know, we have to be explicit about addressing disparities, and Dave kind of -- Dave's rebuttal about well, does it have to be explicit?

So I just thought that was fascinating, because in some ways I think I do agree with Dave, but I don't know that it always has to be explicit. I'm going to bring the Denver Health example up because I've been fascinated by what I have learned, you know, in six months at Denver Health.

So yeah again, there's so many initiatives. There's a really great initiative focusing on population health. You know, they did some mapping, geomapping, to see where the disparities hot spots were. One of the issues that, you know, came up very, very starkly was the issue of obesity, saying there's this sense

that Denver is the healthiest city in the country and it's --

Yeah, it is really healthy and, you know, as people at Denver Health say it's really healthy because Denver imports really healthy people. We don't grow them. So there is an obesity problem in Denver.

So Denver Health focused on an initiative to address obesity in neighborhoods that are, you know, low income, minority, but addressed it from a population health perspective and are looking at everything from sugary beverages to really looking at these multi-level interventions in terms of what the health system can do, what you know, what community organizations can do, what schools can do etcetera, and they are showing great results.

I mean you're seeing, you know, these really great outcomes, but they're not talking about it as an equity initiative at all. It's not even being discussed in the realm of equity, even though the populations are disparities

populations. So it's absolutely happening. So that brings me to my last point, which gets back to, and I know that you've already expressed support for this.

In some ways that tells me that organizations are in fact doing things. Clearly, there's not a tidal wave of change. Clearly, there's a lot of room for improvement. So in no way am I saying oh, you know, we've arrived. But there are organizations that are focusing without being explicit on initiatives that focus on equity.

So I think it brings me back to this notion that if we create a road map, we need to kind of start to extract those examples, and show organizations how to put them into a framework to show that there is this work taking place, because I think we're losing the opportunity to learn from the organizations that are doing it.

You know, so my work at Denver Health and then, you know, going back a decade; my work at AHA, at the American Hospital Association, I

think that there is this tendency for organizations to -- there's kind of almost a domino effect. There's recognition that, you know, so many are doing it; why are we not? It propels change.

So I just -- I wanted to connect those dots, because I think it's just really -- I think that conversation that both of you had was just incredibly insightful.

MEMBER COOPER: I agree, and now I do have my card all of the sudden. And I'd just respond just briefly.

CO-CHAIR CHIN: Go ahead, Lisa, yeah.

MEMBER COOPER: I agree and I don't know that I have the answer. The concern that I have with not being explicit is that the interventions that are put in place are not the appropriate ones. So if we're not being explicit that it's an equity issue, then the intervention could be a generic intervention for any community or any group of people with a particular problem, but without taking into consideration the special

cultural issues, the special social issues that need to be addressed, so that they aren't really tailored or targeted appropriately.

So that's the main concern. I mean you can call it whatever you want to call it, but as long as it's really addressing the critical issue.

CO-CHAIR CHIN: Fascinating discussion. This sort of harkens back to Tom's point about well, improving health in minority population versus disparity reduction, or Lisa's point, look -- a little bit earlier about well, how are you defining equity.

If you use Lisa's sort of definition there, then we're on the same page that the care is tailored for the patient population in mind, which when you look at the example of like the targeting of specific neighborhoods and that is very tailored, as opposed to well the one-size-fits-all approach. So some of this may be the terminology issue in terms of the discussion.

So I think it was Bob, Philip, Nancy.

MEMBER RAUNER: Just want to follow up a little bit more on Tom's thing about you need to make sure the safety net clinics are brought into these programs in the first place. So with the ACOs, they can work, but only if the FQHCs are invited in and there's a leap of faith to bring them in.

The two other big groups that are left out are the critical access hospitals. Because of their cost-based reimbursement, there's actually -- they're often out of any incentive or disincentive programs. The same thing happens with rural health centers, because through a quirk of Medicare rules, they actually get paid through Part A instead of being paid through Part B like most physicians do.

And a lot of the incentive programs are tied to Part B payments. To the rural health clinics are often written out. They're actually written out of meaningful use, for example. They didn't get the incentives because of that. So the Medicare -- this was something in the rural

and small provider panel a couple of years ago we put out that still has not been changed.

And so your rural folks are still left behind in all of these discussions because they're written out of the incentive programs, and until Congress or CMS changes that, we're still leaving rural behind.

CO-CHAIR CHIN: Thanks, Bob. So we have Philip and then Nancy.

MEMBER ALBERTI: I just want to do two quick comments. One to make a pitch for being explicit. I was at a conference last week that was focused on quality improvement, population health management. Presentation after presentation after presentation, all of the pop health efforts were completely internal. There were no connections to community health. There was no partnership and understanding the special needs of populations.

I feel like we are not explicit in the work. It doesn't usually get done and the example that I was telling Michelle earlier,

there is a population health textbook, second edition, 500 pages, 1-1/2 page is dedicated to disparities, zero pages dedicated to community health.

So I think we are going to miss the boat if we're not at least educating, thinking through in an explicit fashion how to connect population health management to community health to health equity. So that's one plea, and I think that's -- I know we parking lotted the kind of the demonstration project question.

But I think a demonstration project that shows, you know, in an ACO setting the benefits, the shared savings benefits that you gain from doing that and in an explicit kind of community health-oriented way would be an amazing study to do.

My second point is really more of a question and a response to what Tom had said, in terms do we focus on process or outcome or both. I wonder if there's a rhetorical value to focus on process as well as outcome. So one of the

other -- one of the presenters at the same conference was amazed.

She was a community health person, said you know, we are top 100 quality and on these different rating systems. But yet our county is like bottom of the barrel in the state. So how can both of those two things be true?

So it might be that despite the fact that you have all these great quality processes in place and there might not be an inequity, when you actually look outside of the hospital and think about the health equity issues, it's hard to square that circle. We're doing a great job with our processes, yet our community health outcomes are so disparate.

I think there might be some kind of art value or conversation area, a talking point value to say despite the fact that you have great processes and we can demonstrate that because you don't have that gap, look at these other gaps and how do you begin to reconcile those two facts, and there could be some rhetorical value there.

CO-CHAIR CHIN: Thanks, Philip. So we'll go Nancy, Ninez and then we'll circle back to the phone folks. So phone folks, think of your questions or comments.

MEMBER GARRETT: So I really appreciate the conversation of Romana and Lisa. I think at my organization, we also have that similar conversation, because a lot of the work that we're doing for our various populations, it really is health equity work. But because populations are so unequally distributed across providers, it ends up being our whole population if you add it all up that we're working on, right?

So if we can reduce, if we can improve outcomes for our safety net population, we're reducing disparities, right? So but at the same time, we want to be sure we're culturally competent and sensitive to the very diverse needs within the subpopulation. So it's an interesting, important question I think.

I just wanted to offer a really

specific recommendation that I feel like we could make within the National Academy of Medicine report, in terms of the question about how equity can be incorporated into existing CMS programs. So we have add-on payments for social risk for hospitals, the disproportionate share payment. There's not an equivalent for outpatient settings for physician groups.

So I think there should be. That would be a way to get resources to the populations that need them the most, and I think we could make that recommendations. So I offer that as a suggestion.

CO-CHAIR CHIN: Thanks, Nancy. So Ninez and then the phone.

CO-CHAIR PONCE: I'd just suggest that for the NQF reports and for this committee that we get at definitions, because I'm from public health. We do population health and I think health equity is pretty rampant in my circles. But -- which is so population health I think is different from population health management.

Just again that discernment, and then equity, as Philip described it this morning in terms of that is about, you know, access to opportunity that's not disadvantaged by socially constructive factors is one definition, and then the definition of the tailored. It's not about giving everybody equal things and access, but it's about giving them what they need and hearing from them about what they need.

So I just think that we need to have more definitions, because even in the reports that we've submitted to CMS, I think that there was -- we use disparities, inequities and equities, equality and if we could be -- if we could get a consensus on the definitions, it would -- that understanding can actually better inform policies in what we're trying to do.

CO-CHAIR CHIN: Maybe that's one thing staff can do that for the final report, that the definitions of some of these key terms like Lisa said, and we can do it by email in terms of the consensus, those iterations and all. Phone now.

So anyone on the phone have comments or things they need to say?

MEMBER SANCHEZ: Yeah. This is Eduardo. I want to underscore what I think is important to continue to explicitly call out, disparities and equity, and that I'm not a believer that rising tides raise all boats, because some boats have lead weights and some of them don't.

And in that vein, I do think that the conversation that's being had in addition, not in that vein, in addition, the conversation about the different ways that population health is used, and that health systems use population health in a very, very different way. I mean they're talking about population medicine, not what I would call population health, and so explicitly defining population health in any of our documents I think is really, really important.

CO-CHAIR CHIN: Thanks Eduardo. Are there others on the phone that would like to

comment?

MS. BURWELL: Yes. This is LaWanda Burwell from CMS, and I'm not speaking as the person who works with some of the programs that reimburse for quality and what-not. But I am also a National Baldrige Examiner and I think that in this discussion and other people have made the point also, that that's the gap between this looking at disparities and minority health. It has to do with looking at outcomes.

This is very hard in the medical area. It's very possible to have a successful operation and the patient died. So I think that there needs to be more of a focus on outcomes, looking at those outcomes, stratifying those outcomes and then doing the root cause analysis to decide why we think are differences in the outcomes.

CO-CHAIR CHIN: Thank you. Others on the phone?

MEMBER FISCELLA: Yeah, this is Kevin. I think this may be an opportunity to begin moving measurement to outcomes using an equity

lens as others have suggested. But beginning to really focus on using measurement of rates of changes in smoking cessation, you know, reduction in obesity and improvements in physical activity, as well as other measures that have population impact like, you know, HPV coverage or HIV viral load and so on.

But I think that this could be an area for, you know, for piloting of these by CMS, particularly if there were, you know, significant dollars, you know, attached to it, enough to really incentivize the kind of partnerships that we've all been talking about.

My second point is I don't think we should forget about while still keeping a broad lens, the socioeconomic disparities across the spectrum, and Bob has already alluded to this in terms of the rural population.

But you know, this really applies across the spectrum and I think being able to track those and measure those using the best available measures we have while continuing to

work for -- to get individual levels collected.

But I think we need both a socioeconomic disparities focus as well as a broader racial, ethnic, minority, linguistic and disability focus.

CO-CHAIR CHIN: Thanks, Kevin. Others on the phone.

MEMBER BERNHEIM: This is Susannah. Two quick things. One is I really appreciate people emphasizing the importance of our definitions and the ways in which different concepts of population health get really mixed up. As we talk about health equity, I think it was Ninez pointed out that, you know, there's been a couple of pieces that I think we really have to incorporate those.

One is the concept of access and opportunity but the other is tailoring care, that ultimately what you're looking for when you're talking about health equity is that if two individuals are in the same circumstance except for a social risk factor, that they have equal

chance of a good outcome.

That's what we're aiming for, and so tailoring of care is important to that. So that's just affirming what people said, and then I have one recommendation for us, and this goes back to something I think Tom, and I don't remember somebody said, about how if you just focus on narrowing gaps, you can narrow gaps by bringing the more -- the population with fewer social risk factors down to a level of a population with social risk factors. You can do it by getting equal outcomes that are equally bad.

So I think one of the things on this bullet about how can equity measures be incorporated into existing CMS programs, I would think it would be good if this committee stated clearly that equity should not be rewarded in the absence of a measure of overall quality, that you have to look at equity in the context of overall quality, to prevent incentivizing the wrong thing. So I think that's a principle we should

state in our work.

CO-CHAIR CHIN: Thanks Susannah. That's a nice example of like a deeper dive into some of the issues that like I think it was initially Tom and Helen raised, and so we'll probably do that for some of the other issues also. Anyone else on the phone?

MEMBER SCHOLLE: Hi, it's Sarah. I just wanted to comment. I agree with a lot of the things that are coming through here. I wanted to highlight a couple of ideas.

So we've tended to think more about these issues and ways to prevent harm for organizations that take on safety nets, and I think we've turned it around to making it more about incentives to providers for taking on more difficult and challenging populations, that that might be a framing that would actually go beyond looking at, you know, predicting the needs of a group but actually expanding the expectations for all providers or organizations because the safety net provider is not big enough to do it all and

isn't doing it all now. So I wonder if that reframing could be helpful.

The other thing that, you know, we've thought about in some of our work, we've tooled around this question of collaboration with community organizations, and not wanting on the one hand everybody to reinvent the wheel by creating their own connection or their own special collaborative with one group or another.

But -- and also trying to build up the resources. So in that discussion earlier today, we talked about collaborations and partnership. I wonder if what might be the ways to encourage collaboration among entities that might otherwise be competing. It's a little challenging because health plans in the same market will compete against each other.

One way that we're seeing some health plans deduct or seek NCQA's Multicultural Health Care accreditation, and I gather it is because they feel like that will set themselves apart from others. It's really a market advantage to

them to focus, say they have this focus on multicultural health care.

But there's also an opportunity to try to encourage, especially in smaller practices or smaller organizations, collaborations within a community, and participating in those collaborations focused on equity issues since some communities will have more resources available than others, and it may require, you know, greater investment in the community and greater collaboration to serve some of these needs.

CO-CHAIR CHIN: Yes. To the same point Sarah that I thought you were going somewhere else with that also, that is also raises the issue of there may be some things with some of the public health social determinants which are part of the commons, that it may necessarily in the interest of any one organization, but you know, you can -- as a commons issue unless there's sort of a group effort to -- for everyone to play the role.

So I know Kevin wants to speak. We'll do anyone else on the phone. Then we have Emilio, Tom and then we're also going to circle around the people that haven't spoken yet, except in the introductory parts. So I know it's like Lisa Iezzoni, Christie, Ron, I think Ignatius, and then we'll rotate from there. So, Kevin?

MEMBER FISCELLA: No, I'll pass. I spoke. Thank you.

CO-CHAIR CHIN: Anyone else on the phone that hasn't spoken that would like to comment?

(No response.)

CO-CHAIR CHIN: Okay, Emilio.

MEMBER CARRILLO: Yes. Going back a few bullets, the discussion that we had on promoting connections between, you know, population health, community health disparities, how does it all align, and I think that the model of the neighborhood as a unit of measurement is where population health meets community health, because basically you have a well-demarcated

community that has certain demographics, that has X number of social services, Y number of health care services and has already existing collaborations or lack of collaborations.

And this can be studied and the multiple factors can be deconstructed in doing so. That also speaks to the next rubric about the CMS programs, and you have the Accountable Health Communities program, which is precisely that.

It's basically, you know, determining geographic areas that are confluent and that basically share certain characteristics, and then interventions are made and measured. So I think that that could be a way to bring the two together.

CO-CHAIR CHIN: Yeah thanks, Emilio. One thing we should probably then circle back a little bit later is this issue of specifically, how do we address some of these social determinants of health. So it's a little bit separate then, a little bit separate from the

issue of like the in-hospital system things. So it's a related but sort of different set of issues to sort of think through. So Tom, and then we'll march through the remaining folks.

MEMBER SEQUIST: I just quickly wanted to say from what I was saying before, I wasn't suggesting we shouldn't do race stratified reporting or equity measures in particular. But when you're asking to your question of how should CMS approach incentivizing or others, I was suggesting that doing accountable care programs but weighting them towards outcomes is a way of incentivizing action on equity.

CO-CHAIR CHIN: Thanks, Tom. Lisa.

MEMBER IEZZONI: Massachusetts just got an enormous Medicaid waiver, and CMS has something like 26 quality measures that they're kind of requiring for their -- let's see, it's called the Delivery System Reform Incentive Program. The acronym is DSRIP, and I'm on their quality measure committee.

So CMS has actually been very, very

participatory with Massachusetts in coming up with what these measures are. I am on the committee and we have a kind of cone of confidentiality around us, that we're not allowed to talk about it. But they actually have awesome measures for community-based organizations that are collaborating with these Medicaid waiver organizations.

And so once that cone of silence is kind of breached, it might be worth people looking at what some of those measures might be, that might give some examples of what CMS is interested in.

MEMBER CARRILLO: Actually the New York program has been going on for almost three years, and we have those measures that can be shared. They're open now.

MEMBER IEZZONI: Yeah. I don't know whether the Massachusetts measures are any different. I have no idea about that, yeah.

MEMBER CARRILLO: They should be very -- CBO's connections.

CO-CHAIR CHIN: Emilio, if you can either email the link to the website to staff, and maybe you can share it. Yeah, okay. Thanks, Lisa. So Christie.

MEMBER TEIGLAND: I'm still -- I'm still way up here thinking about all the people who have fallen through the cracks, who aren't even insured so they're not even being measured. So we're not even sure what the level of disparity is, and you know, we're now talking about the -- I'll get a little political too, since Lisa did, you know.

The 24 million people that we just insured for the first time losing their health insurance, and you know, a lot of statements about homelessness is a choice and not everybody deserves health insurance. You know, what do we do about that? What do we do about the bigger education issue? Okay, so I know you're not going to answer that.

That's what I'm sitting here struggling with, because this stuff all seems

like these people are pretty advantaged compared to the people I'm talking about, right.

CO-CHAIR CHIN: Okay. Thanks, Christie. Ron.

MEMBER COPELAND: So I'm not sure what we're responding to but --

CO-CHAIR CHIN: Just your introductory. So everyone has an opportunity to whatever you want to say in terms of this issue of like how should these measures be used and public reporting and payment programs.

MEMBER COPELAND: Okay. So just based on the conversation we've been having probably the last 15, 20 minutes, I think there's a -- I think there's a set of quality standards that an organization defines for the population it cares for, and how it defines its scope of responsibility.

So that could be our official patient population that we care for, that are patient members and in our system alone, or it can be that as well as the broader community

neighborhoods that our geographic footprint is in.

We have an obligation to our patients and we have an obligation to improving the health of the overall community, and we have different strategies in collaboration of how you do both of those as opposed to one.

But I think on the context of your accountable population, I think you have to have a set of standards, quality standards for what you want all your population to achieve. That's how I think you keep the organization honest from the quality improvement standpoint, and any groups that are not meeting your standards, however you stratify, you have an obligation to get that population, that segment at your standard level, whatever that takes.

Whether you call it equity or not, that activity is going to help eliminate disparities if you have standards and you're trying to move those groups. But I think the comments around whether it's explicit or not, I

think that's relevant because I think part of what this activity is doing is one, recognizing that there's a need for socializing and understanding the concept of equity.

Number two, you're going to find that when you're tailoring interventions when you see these gaps through stratification, including socioeconomic stratification and you want to intervene, you're going to find that one solution does not fit all, because the root causes for different population, different individuals are going to be different.

So you have to have a mechanism by which you're willing to invest in those solutions, build the collaborations, the skills and through incentives or otherwise to tailor those solutions to those segments, to move everybody up at your quality standards or above and continue to work on that. The reason why I think that's important is using our organization, for example, in our efforts to close the gaps on hypertension control, based on -- and our target

was African-American populations because that's where we saw the biggest disparity group among all of our segments in our overall.

But those gaps were -- everybody was still at the 90th percentile or higher, including our African-American population. So if we just said we're doing quality work and all populations are at the 90th percentile or higher, we've met our baseline quality standard, we're done.

But we saw gaps, and so if our aspiration from an equity lens is we want everybody to get optimal outcomes, we felt it was necessary and appropriate to go to the next level to understand the gaps around control, and then to tailor interventions to begin to close that.

We found tailored solutions based on a lot of the tools and interventions that we've been talking about today, and we've been able to narrow that gap almost to nothing, even though it was started at the 90th percentile and higher above. So I think it really depends on how an organization defines its mission, its values and

its playing field, and there's some minimum standards I'm sure we all have to achieve.

But then I think organizations, based on their capacity, their mission and so on, they decide how much more aggressive they want to be in trying to close those gaps or is it worth it or not, and people answer those questions differently.

So I think what we're talking about in terms of CMS, CMS would have to be in a position to say everybody that we pay to provide care to populations, we've got to have some minimum standards that we expect everybody to achieve and be worthy of those payments and so on, and gaps that are measurable have to be closed if they're not at that level, et cetera, et cetera.

That's kind of the minimum playing field that everybody has to be addressing. So for us, is that the context of which we're talking about measures and interventions, and recommendations, or is it something more aspirational than that? I think that's something

we just have to decide.

CO-CHAIR CHIN: Thanks Ron. Those comments synthesize a lot of the current discussion in terms of the next package there. So we'll do Ignatius and Michelle, and then we'll have a break time. We'll take a 15 minute break at 3:00, so Ignatius.

MR. BAU: So I just wanted to raise a question that has come up, which is is there a single measure or set of measures, if a payer or a provider were looking at to work on equity, and I've always -- my response has always been to resist that, to say that there isn't like one magic measure to add.

So I think in this framework at some point we should have that discussion of do we want to explicitly sort of take that on, because in a lot of program design, innovation programs, Medicaid programs, they're saying we know we want to work on chronic care. We know we want to work on hospital measures. Is there an equity measure, and again it's more that standalone

rather than the integrated approach.

But I do think that question comes up enough that we may want to explicitly address it at some point.

CO-CHAIR CHIN: That's a good point Ignatius. We should probably come back to that. It's come up a little bit in the discussion today, people saying well, people want actionable items. So that's going to be more specific.

There is an existing CMS project that I think NCQA has contracted with right now to look at that question of is it a good idea to come up with an equity measure, single composite equity measure or not, or I think maybe that's a simplistic question.

It's more are there purposes for which a single measure is the right thing, and then are there other purposes for which other measures are the right thing? So Michelle, you get the last comment before break, and we'll break.

MEMBER CABRERA: Thanks, okay. You know, I think on the question of should it be

explicit or not, Dr. Copeland just kind of did a great job of explaining some things. I also think that there -- one of the things that I've noticed in this conversation is the tension around sort of whether you're a provider who's interacting with demands for quality improvement and measures, or whether you're at a higher level payer-purchaser.

It's striking to me that considering that I work primarily at Medicaid, it's in-state level, to hear like Medicare is still running programs that are around hospital quality. That sounds overwhelming from like a numbers standpoint and trying to drive, you know, change over a ton of individual health systems.

I think because the trend is away from that kind of relationship and more towards the managed care relationship, we also need to think about how we put pressure on large purchasers like CMS and state Medicaid programs to not explore health equity because of simply the business case. I think the business case does

need to be made, right.

But because of the moral imperative to them, right? That they are the target for the moral imperative argument. On the private commercial health plan side, I think that's going to be a little bit harder. But if you start with large public purchasers, I think it's a little bit more in alignment with who they are, what they're supposed to be doing, et cetera, and I think that's part of where we do need to sort of target this emphasis on you need to be the one to set the goals and hold people accountable because why? Because of moral imperative.

CO-CHAIR CHIN: Yeah, thanks Michelle. That's one of the issues that actually we have not talked about at all, that I think we do need to talk about before the end of the day, this fear that if you design the payment programs or incentives poorly, you could actually be counterproductive in terms of basically removing people's moral sense and it could actually be counterproductive.

People are going to start being driven purely by money as opposed to the moral mission also. So it's really worth coming back to. So let's break and come back at 3:15. Great discussion.

(Whereupon, the above-entitled matter went off the record at 3:03 p.m. and resumed at 3:19 p.m.)

CO-CHAIR CHIN: Okay, guys. This is I think a great start, a great start to the discussion. If you can go to -- I'm going to jump around a little bit. If you go to like page five -- well, the 3:15 agenda item, which is the Guidance on Incentivizing the Reduction of Disparities.

So it may make sense to segue to the discussion of bullets 3, 4 and 5, and then we'll go back to some of the more granular items that were in the previous agenda item. And so the third bullet is how do we most effectively use payment to reduce disparities?

The fourth bullet is how do you ensure

adequate flow of funds to address social determinants of health and preventive infrastructure under different payment mechanisms, ranging from P4P type value-based payment programs, the different forces of global, capitated and bundled payment.

Then the last bullet was are there other ways measurement can be leveraged to reduce disparities. So we'll segue from the 30,000 foot discussion to this next level. It's still reasonably high level, and then later we'll do like the more granular type of more methodological things.

So let's open it up. So we have Michelle and maybe Bob. Want to go? Okay so -- you want to start or go ahead.

MEMBER RAUNER: I was going to follow-up on someone. I think it was Ignatius talking about like how should we group measures and one way of prioritization, there was a report a few months ago updating some of the clinical intervention strategies, where they actually

looked at the qualities of if we improve these measures, what will be the biggest impact on our population?

There are really four buckets where the qualities were greater than 50,000, and it was substance abuse, alcohol and tobacco. It was lifestyle things like obesity and nutrition, fitness. There was cancer measures like colorectal cancer screening and vaccinations like HPV and flu.

And so maybe, you know, if you want to really improve the health of a population, maybe focusing those as the measures to study first, rather than readmissions for this one minute subgroup. Maybe we should prioritize on the big buckets first.

CO-CHAIR CHIN: Especially on the issue of like that discussion about disparity-sensitive measures and the priority targets. Part of that, the calculus of formula had to do with like the prevalence of the condition and the morbidity and the degree it was ameliorable, that

kind of thing. But maybe that's part of that discussion of like when we talk about some of the prioritization and all.

So other comments. Again, focusing upon now how do we most effectively use payments to reduce disparities, the flow of funds through the social determinants of health, and other ways measurement can be used. We've got Philip and then --

MEMBER ALBERTI: So yesterday --

MEMBER SANCHEZ: Marshall, this is Eduardo. I just want to underscore at least some focus on those things that impact lots of people, and that have potentially high impact, and that are somewhat in the middle of the continuum. You know, we've had many discussions about how some of the issues that affect disparities are far upstream.

But I will put on the table blood pressure control. It affects one out of three adults. There is disparity and prevalence and awareness and control, and it is one of those top

five contributors to life lost on any list you ever look at. It's in the middle there.

Not hospital care and not totally community-based, but absolutely something that could be helped by community clinic linkages.

CO-CHAIR CHIN: Great point Eduardo, and maybe that's going to be one of the topics for tomorrow morning. Again, what's going to happen is after this afternoon, the staff's going to do their magic in terms of like sort of organizing some of these comments into a coherent whole, prioritizing some things.

And then it gets back to -- ultimately it's the issue of like I think Lisa Cooper had mentioned that well yeah. When it comes down to it, you have to be careful about then like tons of measures versus selecting the priority ones and issues that you and Bob and Helen raised earlier about then the -- I guess the prioritization and criteria for disparities measure.

So I think we have what? Was it

Philip and then Romana, and then Kevin I think was in the queue too.

MEMBER ALBERTI: So yesterday at the NAM meeting, Karen Joint was talking about trying to develop an equity bonus, and so I spent a lot of time thinking about what an equity bonus might be.

So before I kind of make something up and kind of throw it out there, I was thinking another issue is, you know, how do we make the measures community relevant, right? Every community's different. Every hospital entity treats different populations.

So kind of it's hard to envision one that might be applicable across all communities, where the data are available for all the different populations that might be on the short end of the inequity set. So with that in mind, I wonder if there's a possibility given the five domains that we've created, to think about the equity bonuses, you know, (a) first an institution has to demonstrate a need for the

equity bonus.

So that would kind of automatically tap into that they have a structure for equity in place because they've been able to do the analysis to demonstrate some relevant, salient inequity. And then the bonus would be applied based on a self-referent kind of way, as they improve that one targeted inequity that's most germane for their community.

They would be rewarded for actually showing progress both in terms of the overall metric as well as that gap metric. So I wonder if that's a way to kind of work that bonus idea into the framework that we've set forth.

CO-CHAIR CHIN: So Romana and then Kevin, then Michelle and Ninez.

MS. MURPHY: So I was just thinking about when I think it might have been our first meeting when Cara James was here, and I'm also reflecting on other conversations I had with Cara when I was at PCORI, and asking Cara about, you know, what does it take for something to flow

through CMS in terms of uptake around payment?

What she said over and over again, I think she said it when she was at our meeting, our committee meeting here but I can't remember, is that we need evidence. We need really, really good evidence that, you know, this is the right thing for CMS to be paying for.

So you know, it begs the question of, you know, strength of evidence and I'm thinking about for example the, you know, the partnership or collaboration metrics where, you know, we don't have randomized control trials. But I think we do have evidence that shows that even if there isn't, you know, an intervention that shows that partnerships work, that interventions that use collaboration and partnerships have better outcomes, you know, may be a way to think about this.

But I do want to kind of hit upon the notion of the evidentiary standard, in terms of the measures that we're, you know, that we're going to be supporting and, you know, how the

report, if CMS is an audience for us and I believe it is, how do we make sure that we are speaking to the decision-makers at CMS who make, you know, decisions about payment around evidentiary standards?

I say that, and I also know that CMS, you know, a few years ago said that they would pay for obesity counseling in primary care, and there was no evidence for primary care docs doing behavioral, you know, counseling for obesity. There were a couple of really nice papers written about it. We actually ended up when I was at PCORI funding two large trials, because we knew there was payment for this but there was no evidence.

So I just want to kind of raise the issue of strength of evidence and what that means for payment, because I think that's how we're going to move the needle, is if there's update around the payment.

CO-CHAIR CHIN: I mean your question raises two different issues that are related, but

a little bit different. One is the use of evidence based interventions, and that's part of the PCORI professional framework. So if there was funding for health workers or what-not, or care management.

The second though is more what does it take to get an organization to care about this, to the point where they're going to invest in it and they're going to devote their resources and their front line staff and their management to thinking about how do we do that.

Well then, it's not again RCT, but it's going to be more to say well, what drives behavior? So I think there's like two different issues you're raising, one of which I think is the traditional paradigm of well, you know, an evidence-based intervention.

The other is more well, it really is well frankly, like Lisa said, Lisa Iezzoni said, advocacy to say well equity is an important enough issue that well, we need to have the money flow there in terms of like will the incentives

flow there in terms of the attention. So I think it's a little bit different.

MS. MURPHY: I think it's connected though. I do think -- I mean so if I heard your interpretation correctly, in terms of, you know, health care organizations focusing on equity, the notion that dollars need to flow there. So dollars in this case through CMS. Yeah, I do think that that drives change.

But so going upstream, what is -- what does it take for CMS to say yes, we will pay for this? That's the piece that I'm saying that Cara emphasized, which is evidence, evidence, evidence. Not just evidence-based interventions, but evidence, evidence, evidence. I don't really know what she was, you know, in terms of kind of holding her to a definition.

So I think they are connected. I mean I don't think -- I'm trying to draw the connection, but I don't think they're two different --

CO-CHAIR CHIN: The CMS person on the

phone. I guess like all the behavior people here, there's a lot of evidence in terms of like support of senior management or buy-in is essentially an essential prerequisite to change. So if you have evidence-based proof, I guess you can point to that. But I think I've heard there's a CMS person on the phone that would like to speak.

MS. GRAVES: I think I'm being potentially volunteered.

MS. MURPHY: What I would like is clarity around, you know, what is that pathway and I don't know if it's a clean pathway. But I think for this Committee, it would be really important to understand that.

MS. GRAVES: Hi. This is Darci Graves, and I'm slightly terrified to try to take on this question. I have no doubt that Cara once has talked about evidence. She frequently talked, you know. The times that I hear her use the word three times is usually data, data, data, but I know data data data drives a lot of, you

know, the evidence.

So I think there's that certain -- there's certainly that validity I think. But as you pointed out, there's multiple examples of what's going on. I think we just -- what you all need to work on is that anything we recommend or anything that you all recommend used to being on that side of the thing. I'm still getting used to this side, so when I say "we," I mean "you." Not speaking on behalf of the government, but I am.

Not very well at the moment, but trying. You know, we have to have solid ground. We have to be able to point -- you have to be able to point to something and say we recommend this and this is why we think this is more important or this is the important one over X, and if you have either the evidence or I don't necessarily want to say the anecdotes.

But if we have that kind of consensus, that these are the things where we need to go, you know, as a field, I think that's -- I think

that's important. So hopefully that covered enough.

CO-CHAIR CHIN: I'm sorry to put Darci on the spot, but I think also too I mean like we shouldn't limit ourselves to what we think is feasible now. Part of this is like a road map that is your generic road map, and part of it's contingent on what can be done now. Some of the recommendations may be that these need to be in demo mode, that some of the stuff has not been studied before but should be studied, and then -- and so is appropriate for demos.

But again, if the standard of evidence is well, we know that again, you need to have the attention of senior management to get things done. We'd have to have just extensive proof of that, so I think we're past that bar.

MS. MURPHY: We'll come back to this. I think -- I think I'm also being very mindful of how many measures you've already, you know, you've summarized this. We don't want to have so many measures that we just create another, you

know, measure glut. So I think there is -- you know, I would like this Committee is just, you know, full of very, very smart strategic people.

So I would like to think about how we can be very strategic in terms of -- I love the demo idea. We don't have evidence for some of these things, we just don't. So a demo might be a great recommendation from, you know, from this Committee. So I'm just going to push on that a little bit, because I worry about the outcome of this report being a really great intellectual exercise, and that's not what we're here to do.

I mean that's fun for us. We want it to have some, you know, real world application so --

CO-CHAIR CHIN: Yeah, and it's just a tricky balance to that. Part of the discussion that we've had today has been thinking about how do we help with implementation. I think some of Lisa's points and Lisa in particular, maybe Christie, some of Christie's points too and Ron's points would sum it up also.

But also we need to provide the menu of options and as you said the evidence base and some of our recommendations. But in terms of predicting the tea leaves of possibility, I don't know if that's really sort of the most fruitful use of our time as a committee anyway, yeah.

So anyway, but before we leave, maybe when you get more sort of like the tools out and maybe that's something we revisit tomorrow morning, and maybe thereafter. So let's get our substance first in terms of what we have to work with. So I think, what was it? It was like Romana and then it was Kevin on the phone, and then it was Michelle and then a bunch of cards popped up. We'll say Traci, Christie and Ron. Oh sorry, and Ninez will pop in -- Ninez will pop in when it's her turn, yeah.

CO-CHAIR PONCE: I'll see with the tea leaves.

CO-CHAIR CHIN: Okay. In fact, Ninez, just pop in.

CO-CHAIR PONCE: Okay. So I think

this is an opportunity to comment or make suggestions to the ASPE study B report, and where they are linking -- the Part B is linking the claims data with Medicare community beneficiary survey, and then some American Community Survey, Community Effects.

Because they're doing policy simulations, so this is my tea leaf suggestions. So I think if there's a way to, you know, somewhere between an RCT, an anecdote and demos, I think a policy simulation of how community collaboration could moderate or mediate some of the domains that we're trying to get at I think would be one way, and then also again based on what Philip raised that Karen raised about the equity bonus, which she said we just made it up.

We just added this equity bonus and it ended up, whatever it was, it ended up reducing the disparity between safety net and non-safety net hospitals the most.

So it made me think another way of looking at it, a measurement way is what's the

most cost effective way? Like what's the way that you're maximizing, you're optimizing the reduction of disparities with whatever the investment is of that equity bonus?

Again, working with -- since there's already an infrastructure in place with ASPE, but we have some ideas to help them and they were always please feed us, email us, tell us on some ideas moving to Study B.

CO-CHAIR CHIN: Okay, so Kevin.

MEMBER FISCELLA: Yeah. I was recently reading some papers on the comprehensive health list indices, you know, that produced mortality. Stephen Lim and others have developed that, Joseph Massaro recently have validated some of them using NHANES. But you know, the idea is that you go after a series of modifiable risk factors, and then these are added to a broader health index.

And you know, one idea would be to use the -- to use the index as a rough burden on at least a bunch of preventable morbidity and

mortality, by getting an up-front payment essentially based on need using that -- using those indices.

And then beginning to reward both overall improvement as well as equitable improvement in those indices. That would -- that's one way of reducing measurement burden by having a comprehensive index.

And I guess the latest that I -- I haven't heard many others on the phone know would be what was learned so far regarding the implementation of this big trial that CMS was doing, the Million Hearts trial, that uses a narrow index, ASCDD index as an outcome and what we've learned from that so far and how we might apply some of those lessons either to doing a similar ASCDD index or a broader health index in that way.

CO-CHAIR CHIN: So thanks, Kevin. Kevin's comment was one of the first to address this bullet, the fourth one about like addressing social determinants of health and the issue of

different payment programs. So Kevin suggested essentially a mixed payment model.

So up-front per member per month, bonus payments based upon the social risk that can then fund, presumably, upfront preventive infrastructure, in addition to having some type of, what sounded like some type of P4P based upon absolute thresholds and improvement that would reward then a more piecemeal base of process and outcome measures.

So that's one example of trying to get at this issue of how do you both fund infrastructure up front, as well as potentially desirable activities and outcomes along the way and down the road. So now we can go back to Michelle and we said it was like Traci, Christie and Ron.

MEMBER CABRERA: I think whatever we recommend here, it has to be flexible obviously, because there's so much variation in who might be experiencing a disparity and our members change in that over time as well, right, as you know

from your example with refugees and coming into your community and, you know.

Populations change, priorities change and so I think part of what we want to do is we want to say, you know, to the folks who are interested in this, that they need to allow for there to be experimentation using these tools, these payment tools, the same way that they do for trying to bend the cost curve or improve overall quality, right.

I mean there's tons of experimentation happening there. As our state was rolling out value-based events and P4P and the safety net and then Medicaid, you know, there weren't a lot of examples when that kicked off of successful evidence-based, you know, P4P or VBP in the safety net.

So we're just -- we are experimenting in a lot of different fields. There isn't proof that it's going to work with these populations, and I think, you know, one thing that I do want to flag that I'm concerned about is this hyper-

intense focus on trying to constrain cost to the payers, you know. We have to be mindful, I think, that one, it comes to the goal of improving health for populations that may be just out of reach, as Tom was talking about earlier, right.

But there's the sort of frustration that no matter what we do or throw at this problem, we may never get there. I mean I think there has to be both an acknowledgment of yeah, we may fail and that's okay, and yet we have to reach. We have to try and, you know, that in doing so it actually may cost more. Now if it's going to cost more, there should be accountability, right.

And so the payment system should be designed to attach some strings, not in a punitive way, right, but in a did you really try kind of way. Did you really -- and then if you tried, what can we learn about that example, understanding that it's going to be specific to your population? That's it.

CO-CHAIR CHIN: That's the best edition, Michelle. So one way of thinking about it, maybe that is a different prospectus for any cost analysis. So maybe you're talking about societally being cost effective, yet still having a business case for the plan or the provider. Traci, Christie and Ron.

MEMBER FERGUSON: So going back to Romana's statement about, you know, what we should do as a committee in terms of how we want CMS to act, I believe that they would, and I'm not going to speak for them, but for my own company, as long as an initiative is budget-neutral and we can show that it's budget-neutral in the very beginning then -- and we can show that there are some outcomes, either whether through a demo process, then they'll be willing to put the money up later, when we see that it's working.

So I think that, you know, if look at some of the -- I think the intersection between the federal government in terms of the safety net

for the EPSDT services and what they, you know, Medicaid can say whatever benefits in terms of fee for service. But they have -- there's an extra, you know, federal protection for Medicaid beneficiaries that if it is medically necessary in terms of treatment, that no matter the state agency or the managed care organizations still have to provide that service.

So in a sense, if we can say that at a federal level there is some minimal standard that we expect the state agencies to adhere to the managed care organizations who do the government programs, that that is a way. But again, that's with policy and they -- well, in terms of if -- and we have those that are only do government plans. If it's in the policy, they will do that.

It may not have the funds there, but they will find other ways. They will remove funds from initiatives that aren't showing benefit and now syphon it over to those other initiatives.

So I think going in the stance that it can happen being budget-neutral to begin with, if we instead of doing a whole bunch of measures that really don't show and now we're going to -- the same resources, the money to collect the data and also the human resources now doing a better set of measures and not a lot of extra data and IT work, then that I think will be an easier pill for them to swallow.

CO-CHAIR CHIN: Thanks, Traci. So Christie and Ron.

MEMBER TEIGLAND: So this builds on all three of the last speakers, Romana, Michelle and Traci, and I'm thinking about back to the value-based purchasing, back to making the business case. Every value-based contract is asking you to save money, right? That's the whole premise. Yes, they want to improve outcomes, but they want you to save money.

The fact is a lot of these programs, you know, and issues are not going to save money, but they are going to improve someone's quality

of life. So how do we put some value on quality of life? I mean we have talked a little bit about some quality of life measures, but we haven't talked about quantifying, you know, the value.

I mean we were just approached by a big health plan who has a C-SNP, chronic care SNP, and they're in jeopardy of losing, you know, their status. The D-SNPs seem to have proved the evidence, the I-SNPs too, the C-SNPs not so much. But so, you know, we can certainly do a study and show that people with this chronic condition have better outcomes than people in Medicare Advantage that are not in a C-SNP.

I said and how about cost, we'll look at cost. They said no, no, no. We don't want to look at cost, but pretty sure they already know it costs more. But these people with this chronic condition have a much better quality of life. We worked with another organization that, you know, made a deal about an MS drug, right, that's very expensive but it's keeping people

stable, right?

They're not having those flare-ups of MS that are putting them in the hospital. So part of what the measuring was avoidable hospitalizations, really hard to measure, right. How do you quantify -- and you can do it, but the time horizon has to be a lot longer. So this concept of a measurement year when you're trying to quantify value, it doesn't work.

You need longer than a year probably for someone with MS who's taking this -- your costs are going to be higher. This drug is expensive, but guess what? Your quality of life is way better and maybe there will be cost savings two years, if you look at two years of spending, but not in that one year measurement period.

So you know, these are just some thoughts about quality of life measures number one, and putting some weight on those, but then can we put some value on those as well?

CO-CHAIR CHIN: Your point Christie

made me think of something else, that the programs are in such flux that the issue like cost depends upon the program. Something like MACRA, for example. Well, on the alternative payment model track, then clearly costs are going to be important. The MIPS track, while cost doesn't even enter until what, 2018 or '19, so -- and this is part of the formula for payment.

And so -- and at the level that we have right now, I mean like probably at a minimum we want a menu of options that then can be like applied to specific programs and all. Some of these details probably is going to be beyond what we can do as a committee.

But I think this is getting at some of these general principles and options, and CMS. I mean that's their job in terms of like figuring out how you operationalize, yeah. But it was a good point in terms of one of the points Traci also made in terms of the value also meets the benefits side, yeah. Ron.

MEMBER COPELAND: You asked a question

earlier about how, one of the goals with these recommendations is how do we get organizations to take this work seriously. I think it was something to that effect, and I think my answer to that is that CMS and all health care organizations care about two things at a high priority level, with rare variation, and one is quality improvement.

Any way you cut it in health care organizations and systems, one thing they care about is quality improvement, and the second is they care about cost care management because of resource limitations. So I think how do you make it relevant? I think it's got to touch one of those two areas in terms of how it's constructed and the narrative that's created.

But when we talk about this piece about ensuring or CMS, how do we impact their payment system to drive a reduction in disparities, there's a ton of growing portfolio programs, payment programs that already exist and are emerging now from the CMS lens. So one

question I would have as we contemplate that question is what are those programs designed to accomplish?

Do any of them, if they're as high uptake and they're successful, based on what the criteria and who's eligible to participate, etcetera, do we have any evidence or is it built into the ROI for those that disparities will be one of the intentional or collateral benefits of those programs if they're successful?

So I don't know the answer to that question, but it would seem to me for this Committee if we're zeroing in on how do we enhance and help CMS particularly focus on disparities, what are those current payment programs doing that help this work, and if they're doing some of it but leaving gaps, is that where we should focus our energy in terms of further enhancement?

So that's a question rather than an answer, and then the final thing about this flow of funds to address social determinants. I think

we have to propose some process that makes you eligible to request "investment funds" for taking on social determinants.

So and I'm making this up. It might be demonstrate that you've done a comprehensive needs assessment, whether you're doing it for IRS purposes or not, whether you're not-for-profit or not. We're talking about a different scenario here.

So have you done a comprehensive needs assessment, and as a result of that what priorities have been identified as the priority things to take on and have you demonstrated that those priorities as gaps are based on or significantly influenced by social determinant factors as opposed to not, because this whole notion about -- the inequity really is based on these are things that are one, unjust, unfair, and two, are not -- are removable or preventable.

So theoretically, the things that are barriers that meet those criteria are the things we describe as inequities. There are some

disparities that are based on things that are not reversible, and so you're not going to eliminate those because you can't reverse. So you can't put, lump all disparities together. You've got to be very specific. Those that we feel are predominantly driven by inequity, social inequities. That can be addressed in some fashion.

So if you've done a needs assessment and you've made the case and done the analysis to say these priority areas that we're focused on that have a big impact on lots of people are preventable and can be addressed, and to do that we're going to need -- we're putting together a plan that says we're going to first need to build infrastructure.

We're going to need to do some time determined pilot to address these things over time, and the reward system or payment system needs to be thought about maybe as a certain amount up front to fund an investment of activities, based on a prioritization and a time

frame for achieving measurable results.

That might be tiered results, but getting those results after appropriate deployment of infrastructure is going to result in a bonus payment if you will, because you've done the process improvement. You've addressed it and proven that it's social determinants, and you've achieved an outcome that is measurable and therefore sustainable.

Whether you use collaborative models and all the other tools in the tool kit to get there, that's up to you in deciding on putting it in your plan to bring in what you're trying to take on. So that's just, that's just, you know, kind of fly by night thinking. But I think that type of approach allows for the flexibility or the diversity.

We know everybody is not starting this journey in the same place. It's incorporating or integrating some of the key constructs that are in our framework about collaborating, leadership and so forth and the role of measurement, and

it's putting incentives in the context of investment is the first component of the incentives, where do you have investment and an expectation that there's additional dollars if the outcomes are improved, and it's targeting those things that we've already pre-determined have a social determinant connection as a driver, as opposed to just anything that falls in the disparity gap.

CO-CHAIR CHIN: Thanks Ron, and like Philip is probably saying amen, that there's some synergies with what he said a little bit earlier in terms of the quality of human process and looking to some other conceptual model that we have a little bit. So a lot of things to push the work there.

Your point about like the different CMS programs, I mean you raise the point about need for individualization. The ASPE report that looked at social risk factor adjustment, it's a 400 page report and they looked at like 12 different of the CMS programs divided by like

hospital, ambulatory, long-term care and what-not, and the results differ depending upon the program.

So your point about the need for individualization to program specifics probably is worth looking at.

MEMBER COPELAND: Does anybody have insight on whether any of these, the current programs that are part of the portfolio, payment portfolio have in their constructs or there's a strong belief that they will have some measurable impact on "disparities"?

MS. O'ROURKE: The only one that comes to mind is maybe MIPS that a teeny bit has a couple of equity measures. But I could be wrong on that. That might not even be there.

MALE PARTICIPANT: It's being very generous.

(Off mic comments.)

MEMBER COPELAND: Yeah, and so the reason I ask that question is because so is it taking the things we're proposing and thinking

about recommending, and going back to say they should be integrating to those payment programs? Or have those ships already sailed and therefore there's got to be --

CO-CHAIR CHIN: I think you hit it right on the head, that essentially without groups like us, it ain't going to happen. So this is the chance to basically try to get it on the agenda, yeah.

MEMBER CABRERA: I will just note that there are examples beyond what we have in our field of vision right now. So like we're, you know, we're talking a lot about the Medicare stuff rightfully because it's driving the VBP. But on the 1115 waiver side, I'm aware that because of some ruthless advocacy, there was some stuff baked into what is now called Prime in California.

It used to be -- oh, I looked for it in the ASPE report. It's in there? Oh, okay. The waiver stuff you're going to send them? Okay, good. Yeah, because I didn't see it in the

ASPE report. But so anyhow, there's stuff like that too that I think we need to pull in as examples to CMS of see, you're doing a tiny little thing here or you might --

I think New York's waiver may be. I'm not an expert on New York's waiver, but they might have some stuff too and just pulling those examples out I think will be helpful.

CO-CHAIR CHIN: Great stuff about state examples. So we have David, Philip, Bob, then we'll cycle to the phone people after that.

MEMBER NERENZ: Just wanted to caution about our wording here. I'm looking at the words and I'm kind of a person who takes things very literally. So when we talk about adequate and then we talk about address social determinants, I'm reading a fairly high bar here in both ways. I'm thinking that is we -- lots of our work reports cites about things that are effective.

I don't think that we really apply the cost effectiveness criterion to any of those things, that for a relatively small investment

that big results would be achieved. I just don't think we looked at it that way, and I certainly don't think we only talked about things that were net cost saving. I'm not sure there any of those, maybe.

Okay. So with that as background, if what we mean by the words here is that we're talking about a flow of funds that will allow the providers paid by CMS to address social determinants in such a way that health equities are eliminated, the amount we're talking about is astronomical I think. So big that nobody will discuss it seriously.

So either we say that's not really what these words mean and then we put a limit and say here's what they do mean, or we choose some different words. Because I'm just afraid that if, you know, it sort of hinges on the word "address." If that means solve, fix, eliminate, I have no idea what amount of money we're talking about.

You know, fix housing problems, fix

literacy problems, fix poverty problems, fix local transportation problems? There's not enough money in the federal budget to do all that stuff. So what do we mean? What do these words mean?

CO-CHAIR CHIN: That's a question for the Committee, yeah. Philip.

MEMBER ALBERTI: So I wasn't going to address that first. So you know, the CHNA has spent a lot of time talking about it. That's a completely unfunded mandate, right. So there are not-for-profit hospitals across the country who are turning their gazes upstream because they have to. They received no money. They're being very innovative and thinking about how they address the social determinants of health.

They're actually launching a suite of resources this month focused on how academic health centers are doing that work upstream without any extra funding. So it's possible. Innovative things like using their telehealth capacity to reduce school absences and truancy by

providing care in schools. I mean there are ways that actually don't cost a lot of money.

But the point that I was going to make harkens back to this definition conversation we have about tightening up language, and also kind of some of the bullets up here about mixed payment models and the equity bonus idea that Ron expanded on. So you know, thinking about our structure and the five domains, it seems like domains 1, 2 and 5, right?

So the culture of equity, the structure for equity and the partnerships and collaborations really are kind of our equity measures, right? They're separate from the disparities measure, disparity surveillance that are really in the access and quality bucket when we're talking these differences.

So I wonder if there is some way to kind of merge all these ideas, to think about the idea that Ron had on this bonus idea, the up front payment being tied to a demonstration of need, a demonstration of some aspect of the

culture of equity, the partnerships in place to do the work, the structure of equity in terms of the disparities and the stuff that we sort of bake into these CMS programs that are more universal and central, as Michelle was pointing out earlier, working on these disparities tracking metrics we're identifying gaps, we're incentivizing reduction.

But you could actually go above and beyond and seek some up-front bonus money because you have all these other supporting structures in place. So I wonder if this hybrid model is actually already in the structure that this group has defined in some way.

CO-CHAIR CHIN: Thanks, Philip. So we have Bob, the phone folks and if people can start thinking about -- we're going to start segueing pretty soon into some of the more granular methodological issues, of which maybe the first one to start off is this bullet about when to stratify, when to risk-adjust, when to consider both. So if people can just be starting to

thinking about that. In the meantime we have, did I say what? Was it Bob and then phone. Yep, Bob.

MEMBER RAUNER: Yes. I was kind of thinking about, because of the MIPS comment and then I started thinking more about David's comment earlier that within the structures of the ACO, there is an inherent incentive to improve your safety net clinics, assuming you bring that in, because just from an allocation of resources, if I can bring this clinic that's 35 and 55 percent up versus the other one's 60, it's better bang for my buck to focus on the safety net for the quality improvement side.

There's also sort of an example within MIPS. So MIPS, if you're reporting as a primary care provider in MIPS and you're within an ACO, you actually get bonus points on your MIPS, because you're an ACO. You get full credit for clinical practice improvement. You do get some I think extra, but based on your quality score.

Well you could -- I think it wouldn't

be hard for CMS to incorporate some type of disparities reduction, that if you do this, you might get extra credit on MIPS, or within the ACO you're insured savings percentage is just about the quality score. You could get a bonus for your quality score if you do some of the ground disparities.

So it wouldn't be hard for them to add something bolted onto either MIPS or the Medicare insured savings program around disparities at a later date so --

CO-CHAIR CHIN: Thanks, Bob. So do we have anyone on the phone, and if Susannah is there, if part of your comments maybe you can start some of the discussion on the risk adjustment versus stratification and uses of both type of thing. Anyone on the phone?

MEMBER BERNHEIM: I'm here. But go ahead, please.

MEMBER SCHOLLE: This is Sarah. I have a couple of comments I wanted to make. So I'm actually -- I really like this idea about up-

front payments for infrastructure versus metrics for incentivizing reduction in disparities. I think that's very useful and I apologize if people are hearing fuzziness on the phone, because I just started to hear that.

I did want to make a couple of comments about evidence. One way to think about this is that when we create measures that say -- that are process measures that say you have to do something, then we hit a stronger evidence bar than when we say for an outcome you need to demonstrate that you're achieving similar outcomes or you're reducing disparities and outcomes, because when we say you have to do X, then people will come and say "and Y" and how many community health workers and how do you know, how do you decide what's the right number per person, what's the credentialing that goes along with it?

So as you get, you know, go deeper into that measurement of the infrastructure, it gets -- it gets more complex and the evidence,

while it may say leadership is important, there's what kind of leadership and how you demonstrate and what's sufficient becomes really challenging for a measure developer.

And so it's easier to say, think about that as an infrastructure that's going to support an outcome improvement or reduction of disparities. One of the things that we've been asked to do is to really say that there is a way to reduce disparities, that we know that there are effective interventions.

So I think we know that there are differences in cancer screening rates or cancer mortality rates, the question will be how much evidence do we know about what causes those differences and what -- whether there are effective interventions that can reduce those disparities? So I just want to offer those ideas.

CO-CHAIR CHIN: Thanks, Sarah. Others on the phone?

MEMBER BERNHEIM: This is Susannah.

I'm happy to talk a little bit about the stratification as a definite question. But if others have stuff on this earlier thing, I just want to make space for that first. Okay. I said something earlier, so I don't want to really rehash it.

But there's one key differentiation between the way I think this Committee intends to use patient level stratification in order to eliminate disparities and incentivize equity and risk adjustment. So and I'm thinking particularly the outcome measures, right, measures that are already risk-adjusted for a number of clinical factors to try to "level the playing field" between providers.

When we add a measure for economic status, race or any other social risk factor to those measures, the purpose of that in the context of thinking about equity is, as I said earlier, primarily to reduce unintended consequences, right. That's where it comes up in this conversation. For some people it makes

comparisons among providers more fair.

But the only way it promotes health equity is if it in fact has an impact on sort of the payment for safety net providers, and we've debated that forever. But stratification has the potential to do something else. There's two ways to think about stratification and I want to just say a word about that, because I think --

I'm aware that I'm in the weeds of measurement, that this is a high enough level concept that is worth the Committee's thinking about.

So if you were to produce a report as a process measure, really simplified that shows that Hospital A was in the -- you know, had a 20 percent rate of something for their minority patients and a 30 percent rate for their non-minority patients, you can highlight that there is a difference between those two rates.

However, and so that might help incentivize disparities. It doesn't achieve disparity reduction. It doesn't tell you much

about how they're doing overall unless you know the proportion of those patients. But at least you can see what the differences are.

But there are many measures you can't look at sort of a straight rate, and that's looking at basically our ranking, and if you look at rankings, you may lose the ability to understand within an institution how they compare.

So there's a key issue with stratification that has to do with whether you do it based on how an institution looks compared to other institutions on their social at risk patients, or if you look at how an institution does on their own social at risk patients compared to another one.

So when we talk about stratification, we're going to have to pay a little bit of attention to that. But the bigger picture thing is the thing I said before, which is that I think stratification in general can be used to eliminate and incentivize disparities, and that

primarily serves to decrease unintended consequences.

In that setting, you can use them together. I mean I don't think -- our original committee suggested these are what I'm talking about. But I think it's perfectly reasonable to use them together.

CO-CHAIR CHIN: Thanks, Susannah. So Nancy.

MEMBER GARRETT: I just want to offer a bit more specific idea under the different payment mechanisms that was actually one of the ASPE recommendations, which is to consider new quality improvement programs to provide target-supported technical assistance to safety net providers.

So what that does is it helps reduce the burden of penalties potentially on those populations, but also improves care for the most socially at risk beneficiaries. So it's a specific idea of potentially new quality improvement programs that are targeted at those

providers, given the high concentration of vulnerable populations at those providers.

CO-CHAIR CHIN: Thanks, Nancy. Are there others on the phone besides Sarah and Susannah who want to speak?

(No response.)

CO-CHAIR CHIN: Okay. We'll circle back to Michelle.

MEMBER CABRERA: I have a question actually for all of the smart people in this room. When do you not want to stratify? Because stratification seems great to me. Help me understand when you would not do that.

MEMBER NERENZ: Just can I -- there's a point we have to semantic clarification and now is the point. The word "stratify" can be used in two entirely different ways, and we're going to trip over ourselves over and over if we don't sort it out.

Your use of it implied I think stratification by patient characteristic within an entity, like a given hospital. What's your

infection rate versus black versus white, rich versus poor, okay. That's one way to stratify.

The NQF panel report three years ago, explicitly recommended that along with risk adjustment when it's appropriate, and there are reasons for doing that. But there's an entirely different way to stratify, which is actually what's now in the inpatient proposed rule, which is where you stratify the performing units.

Like you take all the hospitals in the country, divide them up into quintiles based on their percent. Now that's also stratified. The English word applies to that. But Stratify A and Stratify B are two entirely different things. They have different functions for different purposes, different answers yes or no. They're both stratified.

So somehow we need some words that distinguish as we talk about it, which kind of stratify are we talking about.

MEMBER COPELAND: Well, you just did, and I think in the setting of accountability at

an institutional level and accountability at a unit level, or in some cases down to an individual provider level, all those are relevant. We stratify by individual practices, we stratify by medical center, we stratify by our global entity. We benchmark. We stratify in multiple ways.

So it shouldn't be assumed because we're talking about inequity or equity that stratification only talks about ethnic categories or demographic groupings. Stratify is stratify, and you just be clear I'm talking about this combination or this version of it. But it applies all the same.

MEMBER NERENZ: Okay well --

MEMBER BERNHEIM: And David to be clear, I was talking about what we refer to in my group as patient level stratification. So it's stratifying subgroups of patients within an institution for a measure.

MEMBER NERENZ: Yeah, and Susannah I understood it that way. But just in my left ear

I think I heard Phil quietly say we could talk about stratified within or stratified between as a way of keeping the concepts clear. I don't mind that. Actually Ron your suggestion, so there's sort of a middle ground that, you know, let's say that an ACO is your unit of measurement.

Now within an ACO, you can stratify a whole bunch of different ways. You can stratify in patient characteristics, but you could stratify on clinic sites. But that still is different from taking 100 ACOs and stratifying them by some feature.

MEMBER COPELAND: Sure.

MEMBER NERENZ: So I sort of like the within- between. But somehow we've got to sort this out. Otherwise, we're going to be here until midnight and we still don't even know what we're talking about.

CO-CHAIR CHIN: So thank you David, and maybe when people use the word, if they can be specific about their terminology, what they're

stratifying by. I love Michelle's question because it really is a fundamental question, and before we sort of move on to other points, let's have the Committee answer that question. So Lisa.

MEMBER COOPER: So well I mean I'm -- I don't know that I'm the expert in this. I would say one real reason to not stratify is if you don't have enough people in the different categories that would give you a meaningful idea of what you're trying to capture.

So if you have numbers that are too small in your different subcategories, stratifying is not helpful in that case. That's one and there probably are others but --

CO-CHAIR CHIN: Other comments on this particular issue. Nancy, did you want to comment on this issue?

MEMBER GARRETT: Yeah. I would just say so in the-- what's proposed in the CMS rule of stratifying hospitals into groups and then making comparisons within those groups, I think

that that is an advance in terms of better comparability of trying to get at what you're really doing, which is a promotion -- trying to measure the performance on readmissions and not underlying population characteristics.

The danger is that within each of those groups, there's still heterogeneity. So there's still going to be a difference in the underlying population characteristics within each strata. So different proportions of people who are homeless, different income levels.

And so you even with ten in the strata, with 15 strata, you're still going to have that within each of them, and so you're still struggling with that issue. So that's the -- I think that's the danger of it and the difficulty.

CO-CHAIR CHIN: Ron.

MEMBER COPELAND: Yeah. The other category or rationale for not stratifying is when you want to maintain anonymity. Sometimes we're gathering inputs from different units, and Unit A

may have 100 people in it. Unit B may have 20 people in it, and if you're stratifying by any of the demographic categories, people may want to maintain anonymity.

And so you just say you can't stratify below a certain number to protect that, because if there's only one person of a demographic in a group of three or four, that person's going to be identified by virtue of those categories. So that's another reason that comes up.

CO-CHAIR CHIN: More comments on this particular issue like the stratification definition. So Philip and Ninez. Okay. Your comment was like beforehand, another issue or -- you're first then so --

MEMBER ALBERTI: First thing, if I remember, this is before I was on this panel. But I think the original fear is that if you stratified you might hide. I think that's more of a risk adjustment thing that, you know, you might give permission for a particular health center to look bad by bumping their number up

because they risk-adjusted based on their demographics and therefore would hide the disparity.

I think that was the main fear originally of not allowing, or was it just that you might hide the disparity? I think that was just the big, and also it happens in education as well. They don't like to do that for the low income school versus the high income school because they don't want to hide the disparity.

The problem comes when you use it for accountability, because you get penalized for taking care of the poor people essentially. I think that's the biggest fear, is that you might hide a disparity if you stratify or risk-adjust I think.

I think the final two things. I think the final fear of stratification was I forget what they called it at the NAM. It was really an elegant turn of phrase yesterday, where you actually make it seem like it's okay to have different levels of quality of care across levels

of either people, if you're doing this within stratification, or across institution type if you're doing it between institutions.

So it's some, I forget what they called it. It was like psychic something or marketing. I forget what it was. But I think Nancy's point is really well taken. You know if you have within, just between institution or across institution stratification, and the underlying populations are so different, you really do get muddled unless the kinds of things you're adjusting for, right?

So we're talking about this mixed model, where you're stratifying across already adjusted analyses, right? So the adjustment's happening across all the strata. So you're trying to control if you had good community level adjusters, which we sadly don't.

You would be able to kind of clean up a little bit some of those underlying community differences within the strata, so then the comparisons are more legitimate, right?

So I think it's really dependent upon making sure the strata that you're using are well-defined and kind of evidence-based with your histoplots, whatever you're doing. But also the adjusters that you're using within each strata really help you kind of normalize and equalize those comparisons in valid and reliable ways.

CO-CHAIR CHIN: This is an example of like using both then?

MEMBER ALBERTI: Yep.

CO-CHAIR CHIN: Ninez.

CO-CHAIR PONCE: I just want to point those who are not in the SDS, in the risk adjustment group that Dave and Kevin led, that there is a definitions page on stratification, and how that's also different from peer groups for comparison. I mean it's related, but there's a peer groups for comparison and then adjusted for sociodemographic status in like a regression equation.

I think to Bob's point, the latter part where you adjust is actually harder. It

does hide the disparity. The stratification does in some ways, but at least you see how -- I mean you understand that the composition within strata, for each stratum are different.

MEMBER CABRERA: I guess the follow-up to this is do we as a body want to recommend that folks stratify when they have the data and it's not going to violate HPAA, you know. Do we want to just encourage people to, as much as possible in the spirit of both transparency but also moving a conversation around health equity, encourage lots of stratification?

CO-CHAIR CHIN: Go ahead.

CO-CHAIR PONCE: So that gets into the other issue of sample size, right. That's the general question on sample size and I think that that's, you know, each entity is going to have data disclosure review, I mean. So I think that that's, you know, it's a tool to get at a fair way of measuring performance, given the composition of the patients, but it's not -- again, it's not the ends, it's not like it's that

you have to do it.

Although I want to make sure -- I'm going to check with Drew. What did NAM suggest? Didn't NAM suggest to both stratify and to --

DR. ANDERSON: Yeah, both stratify and risk adjust.

CO-CHAIR CHIN: You are of the NAM camp.

CO-CHAIR PONCE: Sign me up.

CO-CHAIR CHIN: Stratification from Helen, because that's one of the specific things that she wanted guidance from the Committee on, this issue of like stratification. What further -- what were you looking for in particular? What kind of guidance?

DR. BURSTIN: I think one question for us as we've struggled over the last -- had this journey over the last several years of this question of adjustment for SES, has been this question of whether at times, as we think about equity measurement, the actual requirement to stratify or peer group comparisons should be put

into the measure specifications we endorse.

Again, if we put it into the specifications there's a higher likelihood it will be used. Actually, back to our early readmission report, which some of you may remember, it specifically was guidance from the Committee that said we believe these results should be used to compare like to like hospitals.

But that was a line in a report that actually had no sort of teeth, as Michelle said earlier, to actually have it used. So we would just -- we just thought it would be useful for the Committee to actually give us guidance here about when these issues come forward and we think this is a really important measure to look at some of these issues.

Should we actually work with developers to bake it into the measure itself, and I know that may -- there may be some downsides we've not considered, and certainly Susannah or other developers should weigh in here. But that would be helpful guidance. Does

that sound right? Good.

CO-CHAIR CHIN: Let's try a couple of Helen's questions right now then, in terms of people's thoughts about her question. Lisa Cooper.

MEMBER COOPER: So I would say yes. I think that if we make a whole separate issue, that that's usually what results in like inaction and inertia. So I think if it's placed like up front when the measure is being developed and we are giving input as to how it ought to be used, and then it's just part of doing regular business, you know.

DR. BURSTIN: Just to follow-up on what you guys answer, and then we would need some clear criteria, which I think part of this we can extract from what you guys have been talking about, determine then based on what is submitted to us, when then we think that needs to be baked in.

MEMBER SCHOLLE: This is Sarah. I represent the measure developers here in terms of

(phone interruption).

CO-CHAIR CHIN: Go ahead, Sarah. We'll do Sarah, Bob. Romana are you still in the queue?

MEMBER HASNAIN-WYNIA: Yeah.

CO-CHAIR CHIN: Okay. So we'll go Sarah, Bob, Romana. Go ahead, Sarah. You're on mute, Sarah. We can't hear you. So Sarah, when you come back on, please pipe in. We'll go Bob, Romana and we'll fit in Sarah when she's available again.

MEMBER RAUNER: This might be a question of distinction of who's stratifying. So a typical NQF measure, it's me and XYZ clinic running a measure on colon cancer screening. For me as the clinic, it's probably not that important to stratify that much. But a payer should really stratify, like Medicaid.

So if I'm comparing in the Ridge where the wealthy people are versus clinics in this safety net area, it's them that need to stratify more than me internally. So I don't know if

that's distinct in an NQF. It's how the NQF measure is used by payers, not how it's used by a particular clinic, for example.

DR. BURSTIN: I think that's an open question. I think at times if you know there are disparities in care, we would want internal examination as well, to see if you're in fact providing equitable care.

CO-CHAIR CHIN: Yeah. So Romana.

MEMBER HASNAIN-WYNIA: So I just need a little clarification. So Helen, your question is about recommendation, this Committee recommending to CMS or to NQF rather, whether going forward in measure development around equity that stratification be put up front. But this Committee itself is not in the business of measure development.

So this is a recommendation for future measure development, not in terms of stratification or not, or a combination of stratification and risk adjustment for what we're recommending within this report. I just want to

be clear.

DR. BURSTIN: Correct.

MEMBER HASNAIN-WYNIA: Okay.

DR. BURSTIN: This is really more -- again, one of our reasons for having you be here is you're the cross-cutting guidance to us on equity and disparities, and so as we look at measure, our core processes of measure endorsement as well as measure selection, you know, might there be opportunities.

Rather than saying, you know, consider adjusting, you know, consider stratification, we would actually say based on A, B and C, when this measure is used it should be stratified. When this measure is used like providers should be -- I'm just speaking. We'd just love your guidance there.

CO-CHAIR CHIN: Sarah, are you back on line or are you still not here?

MS. O'ROURKE: She lost her signal, so she's going to provide comments by email when she gets back to a computer. She said her key points

were around flexibility and transparency.

CO-CHAIR CHIN: Okay.

MEMBER BERNHEIM: And Marshall, can I say something when you get a point in the queue? It's Susannah.

CO-CHAIR CHIN: Sure, we will. Philip, Christie, then Susannah.

MEMBER ALBERTI: I think a question of who should be doing the stratification and what the requirements should be really depend on the purpose of the measure, right? So if we propose today to help institutions think about racking their own disparities with the idea of narrowing those gaps.

So in that case, the institution would necessarily have to do some within-institutional stratification to identify those gaps and track it forward over time. If we're thinking about kind of incentive payments across strata between different organization types like Bob was taking about, then those kinds of metrics would have to be stratified by a payer across or between,

whatever the word we're using.

So I think it really depends on the measure itself, how it's being used and who's using it, and for what purpose.

CO-CHAIR CHIN: So we have Christie, then Susannah. The other thing I'll just give you a heads up, that we've covered most of the bullets. The one we haven't covered yet that we'll then turn to maybe after Sarah's comments are -- if you look at the agenda, there were two sort of implementation questions. It's sort of like how do we secure buy-in for those things measured, how we minimize the burden of additional measures and ensure equity measurement is meaningful.

It's going to be a nice segue into tomorrow morning's discussion about prioritization and operationalization and all. So we'll do again like did I say, it was like Christie, Susannah, and then we can turn to those two sort of implementation bullets.

MEMBER TEIGLAND: Yeah. I just wanted

to underscore about stratification. You just have to be really careful. Maybe it's really useful internally for organizations to see disparities, but if we're using it for public reporting or we're using it for payment and say we say stratify by duals and non-duals.

Now because I could be a dual plan that serves under age 65, disabled, mentally ill behavior-challenged patients and you could be a dual plan that serves 65 plus relatively healthy with some chronic conditions, it's not an apples to apples comparison, but that's what people will do.

So you need to have more than -- and then it gets really complicated. We're going to stratify by duals who are under age 65, who have, you know, physical disabilities versus mental issues. Where does it stop, right? So you get back to the question of you have to risk-adjust before you stratify almost, because once you start to stratify my three or four or five things to make them comparable, you're already down that

path so --

CO-CHAIR CHIN: Sort of the Philip Alberti combined approach, yeah. Susannah.

MEMBER BERNHEIM: Yeah. This is something that happened earlier, was said earlier and I'm kind of going back to David's point. I think we're still not being consistent in our language and it's causing some confusion in the recommendations. And so I'm going to just reiterate something I said earlier, trying to be more precise.

So I think there is a place for what I would call patient level stratification, which is sort of looking at within institution disparities, and I'm trying to use the NAM language. They call this stratified reporting for patient characteristics. That's the language they use in their summary.

What that provides is some information potentially about looking at institutional disparities, and I totally agree with the concept earlier that if you've got small sample sizes,

there's issues of confidentiality, there's issues of whether differences are meaningful, and quite honestly there's issues of whether it's important.

But in the case where there's meaningful sample sizes of two subgroups, using patient level stratification within an institution can reveal within-institution disparities, and could be a useful tool. But the comment I made earlier that I'll now make now that I put it in that context is looking at those results, without looking at overall performance.

So if you're only looking at the difference between two groups in an institution and showing whether it's narrow or broad, you need to pair that with how the institution is doing generally, so that you don't put up an incentive to narrow disparities in the context of overall poor quality for those groups.

Peer group comparisons, somebody mentioned that's how we ended up dealing with this issue in the last report, which I had

forgotten. That's the concept of stratifying groups of entities, you know, hospitals with lots of these patients compared to hospitals with fewer service of a different purpose, and is a little bit less connected to the measures.

So what I would recommend we say is that, as Philip said, depending on your purpose and the measure, there is a role for patient-level stratification if you show within-institution disparities alongside of raw performance on that quality measure.

So I don't -- and I don't know quite what we should say about care group comparisons, but that's sort of trying to get at these between-institution disparities. But I think it's a little hard to bake it into a measure. So that would be my recommendations.

CO-CHAIR CHIN: Thanks, Susannah. So okay. We're now going to turn towards like those two bullets on like how to secure buy-in from those being measured, how we minimize the burden of additional measures and ensure equity

measurement is meaningful, and okay. And Tom is first up.

MEMBER SEQUIST: So on the -- on the burden, I think one of the essentials things is not in the control of this group, but the way to make this not seem like it's a stressful additional burden is you have to take the burden off of all the other domains that are being measured.

Not domains in equity, but safety effectiveness, experience, all the other things where there are hundreds of measures. You have to -- there's just not going to be a way to make this program, equity, efficiently measured enough that you're not going to get people riled up about more measures.

So the only way to do this, I think as a first step is you've got to cut back on all the other measures that aren't equity. I'm not saying they're not important. Everything's important and we have to focus on everything. But I just think that has to be a fundamental

recommendation here, because there's no other way to do it without adding more burden, you know what I mean?

CO-CHAIR CHIN: Thanks, Tom. Lisa Iezzoni.

MEMBER IEZZONI: I concur with the burden concern, and it's not just burden for the plan; it's also burden for the respondents. In Massachusetts, CMS and Medicaid, Mass Health administered 12 different surveys to the recipients of one care, and the population just got exhausted, and so I think that we have to think about the respondents as well.

CO-CHAIR CHIN: Thanks, Lisa, and Nancy?

MEMBER GARRETT: So just reflecting back on some of the discussions we had earlier about the levels of analysis, and we did talk about some potentially state level measures or community level measures, and some of those could be calculated with data that's very widely available. Like is your state Medicaid expansion

or not?

So one way to minimize burden is to think about some of those macro-measures, and maybe there's a way to calculate that with really very little burden, but still have some impact from a policy perspective.

CO-CHAIR CHIN: Thank you, Nancy. Anyone on the phone want to comment upon this, the burden and feasibility issues?

(No response.)

I'm going to ask are there any public comments, either people on the line or people here in the room?

OPERATOR: If you would like to make a public comment, press star 1.

(No response.)

OPERATOR: And there are no comments at this time.

CO-CHAIR CHIN: Okay. So wow. A lot covered, so a lot to work with here. So the current plan is that like so tonight then, like Drew and Erin and the staff are going to look

over these notes and try to cull us into --

FEMALE PARTICIPANT: The magic trick.

CO-CHAIR CHIN: --yeah, and do the magic, in terms of coherent whole. We have some flexibility. So tomorrow morning it's sort of general. We've got this general, I mean like finalize implementation recommendations, finalize the road map. I think in practice what we want to do is in the course of the morning, we want to get far enough along so that we have a reasonable sense of what the general recommendations are going to be, the policy recommendations.

Some of this -- some of us we've been balancing these different factors. So for example, now we've sort of raised this burden and feasibility issue, and the issue that Lisa said up front about, like trying to have a relatively parsimonious measurement set. So how does that jibe in with like this very detailed like five domain conceptual model and these hundreds of measures we have here?

So it will be some type of

prioritization, sort of balancing these different issues. Ninez pointed out like one of the things was to finalize the road map. Well, I mean the road map is always still in evolution, so this will be I guess like an update of the road map, and there will probably keep being evolution through to the September final report.

I just want to ask Erin and Drew, so I guess you're thinking about now like what you're going to be doing tonight in terms of like this -- do you have any questions for the group or any thoughts you have right now before we sort of break here?

MS. O'ROURKE: Sure. So I think my first thought was, I guess Tara if we can go back to the slide on the five over-arching recommendations or implementation activities that we have in our current framework? Keep scrolling. It's actually -- keep going then, or down, down, down, other way, other way. It was the last slide before we started this one, sorry.

So do these still feel like generally

the right large buckets of activities for us to start organizing the conversation we had today? I guess my vision for how we might go about this, to bring you something in the morning, was to put some of the ideas under these larger types of guidance.

But I wanted to get a pulse check with the group before we go down that path, that these still feel appropriate for an organizing structure.

MEMBER GARRETT: Can I --

CO-CHAIR CHIN: Nancy.

MEMBER GARRETT: So one comment is just around the first one, incorporate equity measures. Maybe it's really incorporate equity into payment and reporting programs. So we kind of talked about that earlier, but that might just be a little bit too narrowing for us.

MS. O'ROURKE: Yeah. That's a good edit.

MEMBER SEQUIST: I'm sorry. When you say how will -- when you say when this look

right, can you just reframe again what is it right for, like what --

MS. O'ROURKE: Sure. So basically taking all the ideas that we put out this afternoon, and then trying to organize them perhaps under these -- I don't want to say domains, since we already have domains, but for different types of potential implementation guidance.

MEMBER SEQUIST: Will this be some kind of like a -- these would be -- both would be turned into some kind of recommendation statement you're saying?

MS. O'ROURKE: I think yeah. That's right, that that might be a high level recommendation with some sub-recommendations underneath.

MEMBER SEQUIST: When you say -- I'm sorry.

MEMBER NERENZ: Well, I'll just -- I always take things literally. Is this a good framework? I would just observe, as I think back

on everything we've done today, very much of it goes to the first bullet. I think we've talked very little about the second bullet, almost none but --

On the third bullet, I don't think we've talked at all about the first two points. We've talked a lot about the third. I'm not sure we've really talked explicitly about the fourth bullet, a little bit about the fifth. So to me it's sort of --

MEMBER SEQUIST: That's what I was going to say. I don't remember talking about some of these things.

FEMALE PARTICIPANT: Is it just that we forgot that, you know, to do these things. So I don't -- I'm not thinking that we should scrap these things, because I think they're pretty important, even though they may not have come up today.

MEMBER SEQUIST: No, they're important. I guess what I was -- I'm not disagreeing that they're important. I was just

-- that's what I was asking, because I don't remember talking about some of these things. But I was wondering like the third bullet, does that mean that we would be recommending -- we really think the first area of focus should be preventive care and not hospital care and disparities in hospital care.

Like we just didn't talk about that. That may be what the group wants, but or chronic disease care over preventive care or --

CO-CHAIR CHIN: Maybe what we can do is that maybe the first X minutes, 30 minutes or so we can go into more detail then on some of these things that haven't been discussed as much. I guess it's what two, you said the first bullet, two bullets of like number three. The fourth we talked a little bit about but not -- it hasn't come together systematically.

But that would be helpful. Then we can just add that point too, whether or not it makes sense or not.

MEMBER SEQUIST: And yeah. I'm not

disagreeing with that. I just didn't know --

CO-CHAIR PONCE: Right, and just to again, another refresh. These items are in our framework the bottom part. So just these -- it all connects.

MS. O'ROURKE: And I think these really came to fruition out of the Committee's first meeting maybe back in January of 2016.

CO-CHAIR PONCE: Right. So we can keep what's good, we can add, we can delete.

CO-CHAIR CHIN: Part of the purpose was to have things which are different enough that it's just a lumping versus separating function and thinking about NQF's levers. So clearly number one is a big one. Two is one of the fundamental purpose, I guess, of what NQF is designed to do in general, in terms of the alignment. Three in some way is a subset of one, but then if you put a lot into one, then one gets really big.

Four, this is an interesting one where I guess the assumption was that like if you just

apply like some of these fixes more generally, you may not be really addressing some of the key issues of the safety net that may need to have like bullet one plus other stuff or else contextualize the safety net, that fits with the demo functions in terms of like recommending demos.

MEMBER SEQUIST: And are these part of the recommendations to CMS, or these are just sort of broad-based recommendations?

CO-CHAIR PONCE: This is the road map. This is part of the --

MEMBER SEQUIST: For CMS.

CO-CHAIR CHIN: And that's a great question. I mean like --

MEMBER SEQUIST: Because I'm just wondering like it's CMS has probably relatively less levers for primary and preventive care than for hospital care, let's say if we wanted to focus on where it could have a lot of immediate impact. Just because it already has more programs in that space and --

CO-CHAIR CHIN: I mean why don't I suggest, I mean like CMS commissioned a report, but I think also this is a chance to have like the road map that applies more generally to a lot of the payers and what-not. Like if we add a third bullet to the preventive part, I think that language is in there because of like the social determinants of health and wanted to like prevent the hospitalization in an ACO. So that will announce the idea of preventive, so you have the preventive infrastructures.

So as opposed to everyone investing in like the coronary care cardiology team, you have some money up front for the team that keeps people out of the hospital. So some of this is going to be sort of a language/terminology issue. But again, that could be useful in discussing tomorrow.

DR. BURSTIN: Just as I look at this and I look at this was a nice handout we're happy to share from the meeting yesterday at the National Academy of Medicine. One of the

elements they talk about beyond the payment and adjustment, etcetera, is one element that specifically says restructure payment incentive design.

I think we talked about that a fair amount, and I'm not sure that's captured in that first bullet. So I wonder if we want to bring something like that, because I think you're going to need something to put a lot of those things into. So this idea of payment incentive design might be a way to frame it, to get at some of those. I thought that was good language.

CO-CHAIR CHIN: Yeah. I mean that bullet in some ways is part of one, part of three and actually part of four, but maybe somehow making it explicit in what we eventually come up with.

DR. BURSTIN: Yep.

MEMBER HASNAIN-WYNIA: Yeah. I thought that was about four, right, because NAM's suggestion is about incentive payments for safety net organizations, right. So I think it fits

there.

DR. BURSTIN: They will work their magic.

MS. O'ROURKE: Yes. We got what we wanted here, which is that this needs revision too, and so we'll revise these and then add some additional sub-bullets under these to flesh it out. But we did want to -- since this is a part of the road map we haven't checked in on, we wanted to make sure of that before we went too far.

CO-CHAIR CHIN: Okay. So maybe we'll spend the first half an hour or so or what-not on fleshing out in more detail. Romana.

MEMBER HASNAIN-WYNIA: I'm wondering if we're going to -- if we're going to refine bullet number one around payment design, etcetera, where we might want to loop the last bullet with that same kind of refinement. It kind of then sandwiches.

CO-CHAIR CHIN: For example, what would that mean in terms of -- like a wording

change or --

MEMBER HASNAIN-WYNIA: Yeah, a wording change. So basically to -- in some way to, you know, so the first is to incorporate, and I can't remember the words you used, Helen. But I was scanning back through and listening, and I liked it. But to then -- so that's the incorporate piece, and then the last bullet would be to conduct and fund demonstration projects to test, you know, what we're stating in number one, just to anchor the two.

CO-CHAIR CHIN: So just like the five equity domains, there was designed to be some type of like logic holding this together, us thinking through like whatever bullets we eventually have here, that make sure that like whether it's the order or how the word that hangs in terms of overall conceptual hold. Okay. Bob, did you have --

MEMBER RAUNER: I kind of want to add to what Tom and David said about I don't think we put enough time into the preventive care and

primary care, partly because if you look at all the measures that were in that report, they're almost all hospital-based or very narrowly focused. But most of what the UDS, HRSA measures and the MSSP measures, they're almost all preventive and primary care measures.

They're also the same ones that if you look at the impact on the population qualities, those are the same ones and we have to -- and so I think number four is I think that's why -- what I would hope that we most see out of this next report, is what specific things do we want to put in for safety net organizations, to work on those specific measures, that there should be some incentives.

I think we should make some specific recommendations to do something like add it to MSSP or HRSA or something like that, that we -- I think we need to make some explicit things to incentivize those.

CO-CHAIR CHIN: Thanks, Bob. So we have Lisa Cooper and then Romana.

MEMBER COOPER: So I'm just going to echo what you just said, because that's exactly what I was going to say. The outpatient metrics and the preventive metrics are the ones that are most sensitive to social determinants of health, and the ones that are probably driving disparities much more so than things that happen once people are already in the hospital. So I'm all for that.

CO-CHAIR CHIN: Okay. So I'm sure that will come up again when we talk about it in the morning, in terms of the overall modeling. Romana.

MEMBER HASNAIN-WYNIA: So along the same lines, Nancy made a very specific recommendation around that. So Nancy, I'm going to ask you to restate it, but I want to make sure it got incorporated. I don't know if it did in the recommendations.

MEMBER GARRETT: Are you talking about the add-on payment?

MEMBER HASNAIN-WYNIA: Uh-huh.

MEMBER GARRETT: Yeah. So a specific recommendation of having add-on payments for outpatient services, not just the hospitals. So the dish concept but in outpatient settings for physician practices.

CO-CHAIR CHIN: Okay, and Michelle.

MEMBER CABRERA: I just want to know on this preventive and primary care thing that -- part of what I've noticed and y'all can tell me if this is right or wrong, but I've actually heard a person, I think -- no, I don't want to name names. He was from an organization that promotes payment reform, and he said you know, primary care, you know, it's not a really big cost saver. We don't really invest in primary care.

There's been a lot of focus in terms of these payment reforms on the hospital, inpatient, yadda yadda, because they think that's where you can drive the, you know. So I do think that as part of the big picture, it is important for us to say no, let's pull some resources over

here because of that longer-term horizon being that I think it was Christie was talking about earlier.

There's not been a lot of play in that space, and for that reason that they don't think that there's ROI in the short term in this sort of fervor to get these experiments done. So I do think it's important for us to lift this up and say put some resources into this. Let's play in this space because, you know, the pre-diabetic of today is potentially the diabetic amputee who's now disabled of tomorrow so --

CO-CHAIR CHIN: Yeah. Thanks for saying that. There's an extension of primary care literature, Barbara Starfield et al., in terms of like the value of primary care and preventive care, and this is just what you said. It's because the way the system is set up, it's not a business case because of the way the finance is set up. So that was the purpose of that. Anyone on the phone?

(No response.)

CO-CHAIR CHIN: Thank you everyone for remaining so engaged. It's almost like five o'clock and people are still firing ahead with great ideas, and so essentially I think that's the whole purpose. The whole time of this committee has been really great and everyone's been really mission-driven and value-driven and it's really been great working with everyone.

So people, please relax tonight and so tomorrow, what will happen then we'll start off with a discussion of like some of these bullets we didn't go over in as much detail. We'll flesh that out. Also then like the NQF team will be presenting their magic in terms of like bringing coherence to all the great ideas that people brought today.

And then we'll try to do some in the morning, some of this comment further in terms of like the recommendations, for the policy recommendations, balancing all these realistic things in terms of prioritization, feasibility, what's most important etcetera. Most of the

afternoon will be then looking at the trial period course, and what we want to say about that. You guys have other things to say?

CO-CHAIR PONCE: Just thank you and we did send you the report on the trial period, and are we able to share that (off mic), or have we done that already?

(Off mic comment.)

CO-CHAIR PONCE: Okay, and we may be sending some more materials that will develop into good discussion tomorrow.

CO-CHAIR CHIN: Helen, anything you want to say? Okay. So tomorrow breakfast again at 8:30, and then the meeting itself will start at 9:00? Yeah, okay, great.

MS. MURPHY: And for those who are interested, we have a dinner reception at 5:30 at P.J. Clarke's. So could we get a quick show of hands to see who plans on attending, just so we know?

(Show of hands.)

MS. MURPHY: P.J. Clarke's, oh sorry.

P.J. Clarke, for those who aren't familiar is just one block over. It's -- we can kind of caravan over there. It's just out the building to the right, and then a right down K Street and it's like right across the street.

It's a delight. Just Bob and Ninez? We'll join you. No pressure, okay, all right. So we have a group. Thank you all.

(Whereupon, the above-entitled matter went off the record at 4:50 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Disparities Standing Committee

Before: NQF

Date: 06-14-17

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