NATIONAL QUALITY FORUM

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HEALTHCARE DISPARITIES AND
CULTURAL COMPETENCY STEERING COMMITTEE

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FRIDAY
FEBRUARY 24, 2012

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The Steering Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Dennis Andrulis, Co-Chair, presiding.

PRESENT:
DENNIS ANDRULIS, PhD, MPH, Co-Chair
MARSHALL CHIN, MD, MPH, FACP, University of Chicago
LOURDES CUELLAR, MS, RPh, FASHP, TIRR-Memorial Herrmann
COLETTE EDWARDS, MD, MBA, CIGNA HealthCare
LEONARD EPSTEIN, MSW, Health Resources and Services Administration
KEVIN FISCELLA, MD, MPH, University of Rochester School of Medicine
DAWN FITZGERALD, MBA, Qsource
ROMANA HASNAIN-WYNIA, PhD, Northwestern University Feinberg School of Medicine
ELIZABETH JACOBS, MD, MAPP, University of Wisconsin, Department of Medicine
JERRY JOHNSON, MD, University of Pennsylvania School of Medicine
FRANCIS LU, MD, University of California, Davis
MARY MARYLAND, PhD, MSN, BC, APN, Chicago State University
ERNEST MOY, MD, MPH, Agency for Healthcare Research and Quality

PRESENT(Cont'd):
SEAN O'BRIEN, PhD, Duke University Medical Center
NORMAN OTSUKA, MSc, MD, FRCSC, FAAP, FACS, New York University Hospital for Joint Diseases
GRACE TING, MHA, CHIE, WellPoint
DONNA WASHINGTON, MD, MPH, VA Greater Los Angeles Healthcare System
ELLEN WU, MPH, California Pan-Ethnic Health Network
MARA YOUDELMAN, JD, LLM, National Health Law Program

NQF STAFF:
HELEN BURSTIN, MD, MPH, Senior Vice President, Performance Measures
ROBYN NISHIMI, PhD, Consultant
TAROON AMIN
ALEXIS FORMAN
ADEELA KHAN
NICOLE McELVEEN
ELISA MUNTHALI

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1 P-R-O-C-E-E-D-I-N-G-S
2 9:06 a.m.
3 CO-CHAIR ANDRULIS: Okay, we've
4 gone from a day of being led by a great task
5 master to now you have to deal with an Austin
6 slacker. So I wish you the best of luck.
7 Move me along and I think we'll get nicely
8 through our agenda.
9 Just to give you an idea of the
10 topics that we'll be covering this morning,
11 having been very efficient and effective, and
12 no small thanks to Denice's moving us along,
13 there are a couple of points that are to be
14 considered this morning from the reviews
15 yesterday.
16 One in particular has to do with
17 kind of putting out for discussion, maybe
18 likely to be brief, around the two health
19 literacy measure that were passed by group
20 from CAHPS and from AMA. If there are any
21 points of overlap, discussion, points of
22 consideration about those two measures. And I

1 think you were going to put them up for us to
2 take a look at.
3 So that will be early on in
4 today's agenda. And then we'll discuss
5 measurement gaps. Gaps basically that I think
6 you would have like to have seen brought in
7 context of our measure review but didn't make
8 it, but are nonetheless worth considering for
9 further discussions or internal considerations
10 with NQF.
11 And Helen, who will be here around
12 10:00 or so, had asked us to also consider,
13 and have a brief discussion around, risk
14 adjustments. And especially this issue of how
15 you account for community level factors in the
16 context of the measure considerations. It's a
17 point of, from what I gathered from Helen,
18 it's a point of continual revisiting and
19 consideration of how you fit that.
20 I mean I for one try to figure out
21 how do you distinguish what is supposedly
22 outside the norm, or the scope of,

1 responsibility for practitioners or for
2 organizations versus those that are actually
3 malleable or mutable in some way, shape or
4 form and should be part and parcel of any kind
5 of charge.

6 So that's kind of the general
7 agenda. We'll close out with, I guess, some
8 discussion of next steps. If we're efficient
9 about it we might even get out a little bit
10 early.

11 But I also, before we even get
12 started on that agenda, I wanted to see if
13 there are any residual thoughts, comments,
14 questions, points of order, points of disorder
15 from yesterday's discussion and voting and
16 process that you might want to bring to our
17 attention. Yes?

18 MEMBER EDWARDS: So if we had
19 commentary for any of the measures we should
20 just send it to you, Nicole? Okay.

21 MEMBER TING: So I really enjoyed
22 the discussion yesterday. I would like to

1 recommend, though, as we implement the
2 measures for inclusion that we look at the
3 phasing a little bit. And I don't know how
4 possible that is given that many of the
5 questions are already validated.
6 But I find that the current
7 language focused very much in the care setting
8 and that I would like to see the language
9 expanded to include more stakeholders, like
10 health plans, because there are actually a lot
11 of questions that are applicable in those
12 organizations too.
13 And I don't want our executives to
14 take the easy way out and say, oh, it's a care
15 setting and then not address them.
16 CO-CHAIR ANDRULIS: I guess
17 that's, in part, a question back to NQF, has
18 this come up in previous discussions in other
19 measures? About expanded use or variation
20 thereof?
21 MS. MCELVEEN: Yes, I think most
22 of our measures are really specified more for

1 a clinical/hospital setting. But with this
2 being disparities, which obviously is much
3 more cross-cutting, I can understand your
4 concern, Grace, about making sure these
5 measures in particular are applicable to other
6 care settings outside of what is specified.
7 I think that measure developers
8 try to develop measures in a way that are
9 applicable to a broader audience. But I'll
10 make note of that.
11 CO-CHAIR ANDRULIS: Jerry.
12 MEMBER JOHNSON: It seems that that
13 question speaks to who's responding to the
14 survey, or the instrument. In most of the
15 ones we reviewed yesterday the respondent was
16 the patient or the person. In some of them
17 the questions did ask about leadership and the
18 plan. But they weren't directed towards those
19 persons and so I'm asking for clarification on
20 that point.
21 That seemed to be the heart of the
22 question. Who was responding to it, because

1 some of the surveys did try to speak to
2 leadership and administration. But they were
3 not the ones answering the questions, they
4 were not the respondents.
5 CO-CHAIR ANDRULIS: So what ends
6 up happening in a lot of those circumstances
7 where you take an initial model and you think
8 well that could be very relevant to other
9 settings but it probably needs an adaptation
10 to those other settings. It may not fit, it's
11 not an immediate one-to-one fit.
12 MEMBER TING: Right. So for
13 example right now, I know that CAHPS is field
14 testing their health literacy study with one
15 of our WellPoint plans, as one of the three
16 test sites.
17 So I can see those measures in the
18 future definitely having very direct, tested,
19 validated questions that for patients, for
20 example, questions such as are you asked about
21 your race and ethnicity or language
22 preference. That's definitely something that

1 we an translate to members.
2 Do you find that you get
3 information that you need in the language that
4 you need. That's definitely applicable. So I
5 definitely see there are a lot of elements
6 that we should be asking to assess whether our
7 organization is culturally competent and
8 providing the right services.
9 And I don't want the language to
10 be the initial -- it doesn't apply to us.
11 CO-CHAIR ANDRULIS: Elizabeth.
12 MEMBER JACOBS: Everything was
13 sort of a blur yesterday. But I'm pretty sure
14 the community measure did not pass, right?
15 That community engagement measure. So I think
16 that's a missing link. Actually Ellen and I
17 were talking about that. We don't really have
18 any good measures of outreach to communities
19 or somehow assessing value in the community of
20 the healthcare organizations. So I think
21 that's one of the things that's missing.
22 CO-CHAIR ANDRULIS: That might be

1 also part of the gap discussion. Other
2 comments, thoughts?
3 MEMBER EDWARDS: And I guess,
4 related to that, can someone just quickly
5 review how people would become aware of the
6 opportunity to submit? Because Ellen and I
7 were talking about that earlier.
8 So I can see situations where
9 there might be people who would want to come
10 forth with measures who just wouldn't even
11 know about NQF much less what they should be
12 doing. And how do you broaden that
13 communication?
14 MS. MCELVEEN: That's a great
15 question. So recently what we've done is we
16 have tried to stay more in contact and
17 communication with the measure developers.
18 And by measure developers I mean the folks who
19 traditionally are aware of NQF and submit,
20 typically, to our projects. But what we've
21 done is we've held webinars with them to keep
22 them abreast on our process and answered

1 questions regarding the submission process.
2 The other tool that we have online
3 is we allow anyone to submit a measure at any
4 time, regardless if we have a current project
5 for it. So they have an opportunity to start
6 a measure submission or to begin that process
7 whether we have a project for it or not. That
8 will allow us to, number one, to be aware that
9 a measure is available and give them an
10 opportunity to submit that information.
11 I think there's still an ongoing
12 outreach on our part, certainly to reach other
13 groups and entities that are not aware of NQF
14 and that are striving to, or that have
15 information that could be useful to us. Do
16 you have any other comments on that, Robyn?
17 DR. NISHIMI: Yes, I mean we also
18 depend on you, you know, and Dennis's
19 listserve and others. I mean we do broadcast
20 when there's obviously the specific call for
21 measures. But generally speaking I think more
22 and more people are frankly aware of NQF.

1 What they're probably not aware of is that
2 they can submit measures at any time now.
3 That's relatively new.
4 CO-CHAIR ANDRULIS: Did you get
5 any feedback from folks who might have been
6 more typical submitters of measures about not
7 submitting measures? Did anybody say, well,
8 you know, we don't want to submit this time
9 because?
10 DR. NISHIMI: No. And we usually
11 don't get that kind of --
12 CO-CHAIR ANDRULIS: You don't?
13 DR. NISHIMI: Yes.
14 CO-CHAIR ANDRULIS: Okay. Try and
15 move on to looking at the Health Literacy.
16 MS. MCELVEEN: Well, I'm going to
17 do a short recap of yesterday I want to go
18 through.
19 CO-CHAIR ANDRULIS: Okay, good.
20 MS. MCELVEEN: So again, I just
21 want to thank you guys again for yesterday, we
22 got a lot accomplished. And I would like to -

1 - first, one housekeeping thing. The thumb
2 drives, if you used one of our thumb drives
3 for materials yesterday, we just want to make
4 sure that we got them all back, because we are
5 missing one or two. So not that we're
6 intentionally calling anyone out. But if you
7 have one just remember to return it.
8 And so I'm just going to do a
9 short recap of what we went through yesterday
10 and then we'll start on the discussion around
11 the related Health Literacy measure. For this
12 presentation we'll direct your attention to
13 the two large TV screens to the right and left
14 of the projector, so you know.
15 So we reviewed 15 measures
16 yesterday. One measure we still need to
17 consider is the Cultural Competency
18 Implementation Measure. That was submitted by
19 RAND late, it was submitted this Monday. So
20 we're going to schedule a future conference
21 call with the committee to review that.
22 Out of the 15 measures, the group

1 recommended 11 measures for endorsement.
2 Measure 1821, the measure focused on patients
3 receiving language services supported by a
4 qualified language service provider, we have
5 noted that that measure is recommended pending
6 the inclusion of that footnote to cite the
7 Joint Commission and Office of Civil Rights
8 references.
9 There were four measures that were
10 not recommended. Those were two of the CCAT
11 measures, one was on data collection and the
12 other on community engagement. And the other
13 two measures not recommended were from the
14 Speaking Together program at GW and that was
15 addressing patient wait time for interpreter
16 services and the percent of work time
17 interpreters providing interpretation.
18 So our next discussion, as Dennis
19 mentioned, that we wanted to bring to the
20 group is around a related measure addressing
21 health literacy. And these two measures the
22 group did put forward for endorsement. And

1 that's the Health Literacy measure from the
2 CCAT and the CAHPS item set for addressing
3 health literacy.
4 And so typically in our process
5 for addressing any related or competing
6 measures a measure that has the same measure
7 focus, or the same target population, would be
8 considered a related measure.
9 And so because these two measures
10 have that same focus of health literacy, what
11 we did is we would like to bring these to the
12 group and we highlighted what some of those
13 similarities are between the two measures.
14 So as you all know, there's
15 several questions that have been outlined in
16 the two measures. And I tried to highlight
17 what some of those questions are. And I'll
18 read a few to you because the print is a
19 little small.
20 So for example, in the AHRQ
21 measure it asks, "In the last 12 months how
22 often were the forms from the provider's

1 office easy to fill out?" In the AMA measure
2 it asks, "Were the hospital forms easy for you
3 to fill out?" That's one example.
4 Another is, "How often were you
5 offered help to fill out forms at the
6 provider's office?" And then the similar
7 question is, "Did the hospital staff offer
8 help to you to fill out the forms?"
9 And then the last question that we
10 found that was very similar was, "How often
11 were the instructions about how to take
12 medications easy to understand?" And the
13 other question is, "Do you understand your
14 doctor's instructions? Did you know how to
15 take your medicine?"
16 So those, again, are the
17 similarities. While they're overlapping in
18 certain areas they're not identical for the
19 target population. So for example CAHPS is
20 geared towards the patient population and the
21 CCAT measure is focused for patients and
22 staff.

1 So the questions for the group
2 are, first, if you agree that the measures
3 have the same measure focus. If you do agree
4 then do you also agree that they both should
5 remain endorsed? If that is the case then we
6 do need a justification for that.
7 MEMBER JACOBS: My question is
8 you're not proposing just choosing some items
9 over another, right? Because then if you
10 change the items you could un-validate the
11 instrument, right. So it's like we'd either
12 keep them both or choose CAHPS or AMA, right?
13 Okay, just wanted to make sure.
14 CO-CHAIR ANDRULIS: Jerry.
15 MEMBER JOHNSON: I guess I don't
16 know why we need to choose one or the other or
17 if we think they both work, not just endorse
18 both. Their method of selecting the
19 population in their surveys are very
20 different. I mean one is, as I recall,
21 requires that there had been a visit in the
22 last 12 months. I mean it could be a hospital

1 visit, it could be a outpatient visit or
2 whatever.
3 And then the other one is more
4 directly focused within something that
5 happened within the hospital over a period of
6 the last four weeks or something. Is that not
7 the case with the CCAT?
8 DR. NISHIMI: The selection of the
9 population is less, to me, the determining
10 factor. I think the thing to think about is
11 obviously if they had both been purely on
12 patients then they would be directly competing
13 and the NQF rules, if you will, would have
14 sort of forced you into making a decision
15 about the two.
16 Because these are two different
17 target populations, leaving aside the issue of
18 how the patient pool is drawn, that, in my
19 mind, would be a justification for not
20 choosing one or the other. It's just that we
21 are sort of required by the process to bring
22 this to your attention and for you to make

1 those kinds of decisions.
2 MEMBER JOHNSON: I guess I'm just
3 trying to make the case that we want systems
4 and providers to assess the quality of their
5 health literacy work. And I don't now why
6 we'd want to just say the only way to do this
7 is through one qualified NQF measure. It may
8 be there could be two qualified NQF approaches
9 to health literacy. I'm missing that.
10 DR. NISHIMI: Yes, well in other
11 measurement projects we do require you to
12 choose, because it's about standards.
13 MEMBER JOHNSON: I'm just
14 questioning the wisdom of that, that's all.
15 DR. NISHIMI: Yes. That's a
16 corporate position. To have a single
17 standardized way, because these are different
18 populations, I think, it's a different
19 discussion.
20 CO-CHAIR ANDRULIS: Mara, then
21 Donna.
22 MEMBER YOUDELMAN: So I guess I

1 would make the proposal that we do keep both.
2 Both for the reason that, Robyn, you were
3 saying which is the populations are somewhat
4 different. And also given that CAHPS versus
5 CCAT, who uses them in general, is also
6 different.
7 So I think there's a strong case
8 to keep both with a valid justification and
9 I'm not sure if there's any disagreement in
10 this room and maybe we can just, you know, if
11 anyone disagrees raise an issue now and then
12 we can just vote and move.
13 CO-CHAIR ANDRULIS: Donna.
14 MEMBER WASHINGTON: The
15 populations are different. It actually goes
16 beyond just looking at the patient verus
17 patient and provider. Since one is at the
18 healthcare organization level, that would be
19 the CCAT one, and CAHPS will also be
20 incorporated into MEPS from what I understand
21 from yesterday's discussion. So that further
22 differentiates the two.

1 CO-CHAIR ANDRULIS: Anybody else,
2 because I think we're getting kind of a clear
3 --
4 DR. NISHIMI: Let's put it this
5 way, does anyone object to advancing both
6 measures? Okay. Does anyone feel that there
7 were any other measures, amongst those that
8 you reviewed yesterday, that were related and
9 competing and that we need to consider?
10 These are the two that we
11 identified, obviously, in the list. But we
12 sort of are compelled to ask you if there's
13 any others you want to revisit because of this
14 issue.
15 MEMBER JACOBS: Can you put up a
16 list of the approved measures? Like I said, I
17 think only two of them were not endorsed. Is
18 that right? Four, oh, four.
19 CO-CHAIR ANDRULIS: Grace.
20 MEMBER TING: Okay. So yesterday
21 was really full and maybe I was just dreaming,
22 but were there two somewhat related to

1 clinical cultural competencies of an
2 organization? Or is it just one? Do people,
3 could someone help refresh my --
4 CO-CHAIR ANDRULIS: Jerry.
5 MEMBER JOHNSON: Yes, actually I'm
6 glad you brought that up. Actually the CCAT
7 had a clinical competency one too as well as
8 CAHPS has a cultural competency one.
9 MEMBER TING: Okay, I thought so.
10 Right. So if we could take a quick look at
11 that. I mean, obviously, I think if we
12 endorse both of these we probably will look at
13 endorsing but I just want to make sure how
14 similar or dissimilar they are.
15 CO-CHAIR ANDRULIS: Ernie.
16 MEMBER MOY: Mine isn't specific
17 to that, it's just a generic question. I
18 think it makes sense to weigh a measure versus
19 a measure to see if there's one that's better.
20 But both of these are measure sets. And so
21 if you take out a measure from a measure set
22 all the validation is no longer valid. So I

1 don't see how you break a measure set.

2 DR. NISHIMI: Well we broke the

3 set up yesterday when we didn't endorse it, so

4 --

5 MEMBER MOY: The whole reason for

6 doing them separately is because they had

7 separate reliability and validity testing.

8 MS. MCELVEEN: So from the AMA

9 measure set there was a cross-cultural measure

10 and then we had a cultural competency measure

11 from CAHPS, are those the two that --

12 MEMBER JOHNSON: What was the

13 number on the first one?

14 MS. MCELVEEN: The cross-cultural?

15 It was 1894.

16 MEMBER JOHNSON: Okay.

17 MS. MCELVEEN: We're pulling up

18 the table now to see if --

19 MEMBER YOUDELMAN: I mean one

20 other thing that I can just mention as you're

21 looking for it, to the extent that we all sort

22 of discussed the CAHPS cultural competency

1 subset wasn't really about cultural competency
2 as much as we would have liked. I don't know
3 if there's as much of a conflict if CCAT
4 really is about cultural competency. Except
5 for the interpreter questions. But that may
6 also be sort of another differentiation, is
7 that even thought the titles sound the same
8 that the actual content and topics don't.
9 DR. NISHIMI: Okay, does everyone
10 have --
11 CO-CHAIR ANDRULIS: Donna.
12 MEMBER WASHINGTON: So it's true,
13 I just pulled up the items for 1894, the CCAT
14 measure, and they are more directly related to
15 cultural competency, but those also had the
16 weaker psychometric properties among the CCAT
17 measures that were approved.
18 They only had three items in the
19 patient survey set whereas they had a very
20 robust number in the staff survey set. So the
21 trade off is content versus validity.
22 CO-CHAIR ANDRULIS: Jerry.

1 MEMBER JOHNSON: Might be on this
2 is the same as the other one. I think it's
3 exactly the same question. I would recommend
4 approving both of them. For the same reasons
5 that we just went through before.
6 DR. NISHIMI: Is there any
7 objections to that? Okay so we'll make note
8 that the Committee considered these but
9 affirmatively decided to push forward with
10 both.
11 CO-CHAIR ANDRULIS: Yes, Donna.
12 MEMBER WASHINGTON: I think part
13 of the rationale you can include the
14 difference in populations.
15 CO-CHAIR ANDRULIS: Okay. We're
16 going to move on to a discussion that was
17 started by Liz about measure gaps. Gaps that
18 were not closed or considered directly, or for
19 that matter rejected in the context of our
20 review. And I guess, Grace, you want to start
21 us off?
22 MEMBER TING: Sure. And this

1 question is really maybe more for Robyn and
2 Nicole. In the past has NCQA submitted
3 measures or do they tend to keep their own
4 measures because, you know, they sell it for
5 accreditation?

6 MS. MCELVEEN: They submit.

7 MEMBER TING: Okay. So I'm
8 actually kind of surprised that they did not
9 submit this time around. Or maybe they did
10 and it didn't make it in, because NCQA
11 actually has a whole class multi-cultural
12 distinction certification.

13 And I actually, when I attended
14 training, there are some elements that I think
15 is a missing gap measure. It's a process
16 measure so I don't think it's really
17 quantitative. But I actually think that it is
18 a really important step in measuring an
19 organization's cultural competency.

20 So specifically it's the element
21 on programs. And so they set the measure, or
22 the evaluation element, is having a written

1 program description for improving culturally
2 and linguistically appropriate services.
3 And under that there is a
4 community engagement component and what that
5 might mean or how that might be fulfilled. So
6 they say that an organization should have a
7 program description that includes written
8 objective, a process to improve, which has the
9 community element, measurable goals and an
10 annual work plan. A plan for monitoring
11 against those goals and annual approval.
12 So this is not something that just
13 because you have it your company is culturally
14 competent, but I think that it does speak to a
15 company's leadership commitment to a cultural
16 competency in a class. So specifically, under
17 the process to improve, they want to see a
18 process to involve members of the culturally
19 diverse community in the process.
20 And they said that this could be
21 met through elements for advisory panels,
22 community forums to review and solicit

1 feedback. And/or focus groups. So I think
2 that that's something very concrete and people
3 can say, okay, that's how you might engage a
4 community for feedback rather than just say we
5 looked at the census data and this is what we
6 think.
7 So I don't know whether we want to
8 reach out NCQA and encourage them to maybe
9 look at this element. But they have many
10 other elements that I think are a little but
11 more cross-cutting than just the care setting
12 too. And I just wanted to propose that.
13 CO-CHAIR ANDRULIS: Go to Mara and
14 Dawn and then Ellen and Lourdes.
15 MEMBER YOUDELMAN: I agree with
16 Grace. I wonder does NCQA generally submit
17 its things here?
18 DR. NISHIMI: Yes, and they were
19 part of the previous cultural competency
20 project so they presumably chose not to for
21 whatever reason.
22 MEMBER YOUDELMAN: That wasn't my

1 question though. And I may have just missed
2 this. But for example GW's whatever, sorry.
3 Wow. Thank you, measures, that -- Wow. GW's
4 measures were tested in hospitals. When we
5 endorse them does that mean the endorsement is
6 limited to hospitals because that's where
7 they've been validated? Or anyone can now
8 pick them up and use it?
9 DR. NISHIMI: Anyone can use it
10 but it's endorsed by us as --
11 MEMBER YOUDELMAN: A hospital
12 measure.
13 DR. NISHIMI: -- the applicable
14 care setting will say hospital. But it's not
15 like others can't use it.
16 MEMBER YOUDELMAN: And we can't
17 say, because of the validation that we
18 received, we can't say this hospital standard
19 is also applicable to clinics or provider's
20 offices or health plans. We can't say that?
21 Or we can?
22 DR. NISHIMI: That's --

1 MEMBER YOUDELMAN: That's beyond
2 our scope?
3 DR. NISHIMI: Yes.
4 MEMBER YOUDELMAN: Okay, I just
5 wanted to double check that.
6 DR. NISHIMI: I mean we can
7 indicate that, in narrative, that the
8 Committee also felt that it could be a
9 appropriate, blah, blah, blah. But when you
10 see its endorsement status you will that it's
11 -- you couldn't just change it in that
12 respect. We could try and craft narrative
13 that indicates you thought it could apply
14 broader. More broadly.
15 MEMBER YOUDELMAN: Then I guess I
16 would suggest, and I don't if we have to go
17 measure-by-measure, but I would suggest that
18 we seriously look at that and determine that,
19 because I think some of these will probably
20 lend better to other settings than others
21 might. So I don't know how to do that if you
22 guys schedule it --

1 DR. NISHIMI: So that could be
2 part of the follow-up that we send you, you
3 know, something by email and then you would
4 respond by followup.
5 MEMBER YOUDELMAN: Right, because
6 I think would sort of help with some of the
7 measure gaps. Like, some of this, if it's
8 really only applicable to hospitals then
9 there's just a gap just on practice setting.
10 Not just a gap of we're missing a measure.
11 But we're missing a measure in a setting.
12 So I think there's that duality.
13 So I think a good chunk of measure gaps are
14 just, most of these were developed in hospital
15 settings. So we're looking at having them
16 brought into other settings is a big gap.
17 DR. NISHIMI: You'll have the
18 opportunity to review the report. But also in
19 followup emails staff will query you as to
20 what you think about the existing.
21 MEMBER TING: Right. And that
22 really is a key concern of mine. I really

1 want us to look at healthcare equity from a
2 much broader sense rather than just care
3 setting, because I think that this area is so
4 multifaceted you really need to engage all
5 stakeholders. And I agree with a gap of
6 settings, very much.
7 CO-CHAIR ANDRULIS: It may be
8 worthwhile sending out for discussion, or for
9 feedback, to you some kind of chart that kind
10 of lays out the measures and then issues,
11 broader applicability, issues related to
12 broader applicability, other points that I
13 think we could all comment on. Because I
14 think many of us would be interested in that
15 breadth of consideration. Dawn.
16 MEMBER FITZGERALD: I'm going to
17 get out of the weeds and back into the big
18 statement world here. So earlier in the
19 comments when you were saying, and I
20 understand being the pragmatist here about,
21 you know, if there's two measure that are
22 equally valid that there's sort of this give

1 and take and one has to pick a superior
2 measure.
3 But you know it seems as though
4 NQF is sort of treading into different waters
5 now where we're no longer talking about
6 clinical measures of quality, but perceptions
7 of quality.
8 And I think it's going to be more
9 challenging to kind of have that model. You
10 know I'm sitting here thinking it's sort of
11 like forcing someone in the industry to say is
12 Lean Six Sigma better than ISO.
13 They both have the same measure
14 domains but yet we select, because they're
15 appropriate to our industry or our setting or
16 for whatever purposes.
17 And I know you all have much
18 smarter people than me involved in this
19 process but it seems like there needs to kind
20 of some conversation around how one evaluates
21 culture things like that from a different
22 perspective, because I think it's true that

1 they're more embraced within domains
2 inclusively and not sort of being able to
3 tease out and say well this question in this
4 one matches this question in this one, now all
5 of a sudden we think there's overlap.
6 And I don't know how to resolve
7 that, but it's just a comment because it is
8 kind of a new world in terms of the kinds of
9 measures that are coming up these days for NQF
10 endorsement.
11 DR. NISHIMI: And I don't disagree.
12 I don't think it's really an issue for this
13 project, at this time. But, you know, we have
14 a maintenance process and when these measures
15 come up next time there may well be seriously
16 head-to-head competing measures and that's the
17 kind of conversation absolutely --
18 MEMBER FITZGERALD: Well and I
19 know there's a lot of hospital culture surveys
20 that will touch upon every single one of these
21 issues we move forward. There's a Culture of
22 Patient Safety. There's Hospital Leadership

1 Survey.
2 All of these things are going to
3 have elements that touch on at least one or
4 more of these other elements. So how do you,
5 at that point, given the comprehensive nature
6 of what the assessment is, sort of decide
7 which of this one works better than which of
8 that one?
9 DR. NISHIMI: No, I agree.
10 CO-CHAIR ANDRULIS: And I also
11 wonder whether it would be worthwhile
12 somewhere kind of cross-walking what we have
13 reviewed here with the efforts that NQF had
14 done around cultural competency standards to
15 see where there had been a match. I think
16 that may yield its own gaps. At least, not
17 necessarily in terms of saying, oh you have to
18 come up with a whole bunch of measures.
19 But get a sense of where there has
20 been some fit and some progress of grounding
21 in measurement some of those. And also it
22 links to other work.

1 DR. NISHIMI: I think that will
2 come up when you see the RAND measure.
3 CO-CHAIR ANDRULIS: Ellen.
4 MEMBER WU: Mara, I'm surprised
5 you didn't say something about this. With the
6 gap measures. So I'm really concerned that we
7 don't have a measure around data collection.
8 It seems a fairly easy thing to get at, of
9 whether or not people are collecting race,
10 ethnicity and language data. So I don't know
11 how we address that.
12 And it would be nice to actually
13 look to see if there's anybody who has some
14 health related quality of life measures to
15 talk about. To just get beyond the specific
16 health conditions, but broader. Those are the
17 two areas that I feel like there's a gap.
18 DR. NISHIMI: I think we do have
19 some of those in the Patient Reported Outcomes
20 project. The quality of life.
21 MEMBER YOUDELMAN: And data
22 collection, though, I think that's Mara and I

1 are saying, there is an endorsed measure from
2 the last round that's specific on data
3 collection. It's not the evaluation of the
4 data collection, so that might be the
5 distinction we have to make, because I think
6 in the last panel, it was mostly preferred
7 practices, but I thought we adopted the HRET
8 Tool Kit as a measure.
9 So we have it, but I think what I
10 would say, from what you said, is then we have
11 to sort of get beyond the collection then to
12 the measurement of the collection, which the
13 CCAT was doing but maybe we need to figure out
14 ways to improve on the CCAT because that one
15 didn't get approved by us. Right?
16 MEMBER WU: I just can't remember
17 that about HRET has --
18 MEMBER YOUDELMAN: I'm sitting
19 next to her so it's --
20 CO-CHAIR ANDRULIS: Lourdes and
21 Grace, then Marshall.
22 MEMBER CUELLAR: Along the same

1 lines as what Grace and Mara were saying, we
2 have a great opportunity now, there's 32
3 pioneers, ACOs that have been established.
4 There's five in California, I know there's two
5 in Texas. A totally integrated system to see,
6 using the common medical record, does this
7 continuum of information follow the patient
8 all the way through.
9 And there would be more coming I
10 think starting in July, I think it's the
11 second phase. So with facilities I think
12 that's a great opportunity.
13 I also didn't want to lose the
14 point that Jerry made on leadership, because I
15 think, just like CMS and Joint Commission,
16 whole accountability at the highest level,
17 being the Board of Trustees, with certain
18 specific questions, I think, all the way to
19 the Board and the C-suite, I think it's
20 incumbent because they're the leadership.
21 I mean you can have all the
22 training you want, get all the information you

1 want, but unless that leadership dictates it
2 down it's not going to happen. So I think
3 we've got to hold them accountable to a
4 certain degree as well.
5 CO-CHAIR ANDRULIS: Thank you.
6 Grace.
7 MEMBER TING: Thank you. So
8 again, not to tout NCQA as a possible option
9 again, but NCQA does have an evaluation on an
10 organization's ability to collect and use race
11 and ethnicity and language data. So that's
12 actually their first element. And they do
13 have scoring tiers that says, okay, if you do
14 this then you get 25 percent. If you do this
15 then you get 50 percent, 75 percent, 100
16 percent.
17 And it's a combination between
18 patient directed -- collected, sorry. Race
19 and ethnicity and language I think, based on
20 OMB standards, as well as the use of indirect
21 methodology, which is predictive algorithms
22 using that as a quality improvement tool.

1 So I think that, again, since
2 these are gaps maybe we're not asking NCQA,
3 saying give us your whole tool. But just say
4 that we know there are gaps and the CCAT one
5 wasn't really appropriate could you consider
6 submitting these, where we have gaps.
7 CO-CHAIR ANDRULIS: Marshall and
8 then Romana.
9 MEMBER CHIN: So I just want to
10 raise this issue under measure gaps. I think
11 because of across, I guess, probably the two
12 days and it has to do with, I guess, not so
13 much our messaging and our language. So that
14 the past day, and quarter, we've been talking
15 about cultural competency and sort of like
16 non-disease specific measures of communication
17 and literacy. So fairly general. And this
18 afternoon we may want to talk a little bit
19 about these disparity sensitive measures.
20 But I think it's critical in the
21 final product that we don't have as clean a
22 distinction in terms of, you know, as I'm

1 hearing it I think someone could interpret as
2 well disparities measures really are, it's
3 cultural competency, it's literacy, it's
4 communication. And then this more traditional
5 sort of process in outcome measures that are
6 stratified by REL or SES or something else.
7 So I think that we could
8 misinterpret it. So I'll give you a specific
9 example. I'm part of another NQF Committee
10 called the Measures Application Partnership,
11 which is devising which measures are used for
12 public reporting and incentives and all.
13 And if you picture sort of a
14 committee like this where you're the only
15 disparities person, and so this is a general
16 point that I've been raising at each of these
17 different meetings, and I'm not sure how much
18 it gets trough, because actually they're
19 looking for this group, probably say well
20 we've come to disparity measures we'll look
21 into this group, us here, in terms of what the
22 answer is going to be.

1 But there's sort of this -- you
2 can tell it's sort of like tinged in terms of
3 what they're thinking about. Well, you know,
4 it's say Marshall likes disparity measure.
5 And so, again, I think it has to do with the
6 messaging we're doing but also it dovetails
7 with the discussion we're going to have this
8 afternoon. But how is this going to be done
9 in terms of disparities measures. Measure
10 gaps, messaging, what goes forth in this
11 committee?
12 That's the point I want to make,
13 is then I don't want us to lose then, sort of,
14 these two different components because I think
15 they're complimentary but they are somewhat
16 different in terms of what we've been talking
17 about the past day. And then the usual sort
18 of clinical measures stratified by some
19 factor.
20 It seems sort of implicit I think,
21 in the materials you've been sending, us that
22 you guys, you know, at NQF may not be making

1 this just, maybe distinguishing so that I
2 think people can potentially misinterpret if
3 we aren't careful with how we package this.
4 DR. NISHIMI: What do you mean
5 misinterpret what --
6 MEMBER CHIN: Well for example
7 like this MAP Committee, they can say okay,
8 disparities measures, we're going to focus
9 upon the cultural competency, literacy,
10 communications measures. These are the
11 disparity specific things. And the RDF, like
12 well looking at the other sort of usual
13 measures that they are looking at but
14 stratified by race/ethnicity, somehow
15 different.
16 I think we get it. But I think
17 others that aren't in this area, you know,
18 they hear disparities, I think really it's a
19 danger of us missing the boat.
20 CO-CHAIR ANDRULIS: Yes it's the
21 difference between perceiving them as general
22 measures that can be stratified versus ones

1 that are specific to issues of race, culture
2 and language.
3 MEMBER CHIN: Right I mean
4 philosophically it's this issue of like you
5 think about your pillars of quality and how
6 equity, I mean it's gone from the IOM 6, I
7 think it was Number 6, to the newest IOM
8 iteration, equity cuts across all of now seven
9 pillars of quality.
10 And so it's a philosophical change
11 that I still think that there are many in the
12 outside world sort of view it as sort of
13 something that could be marginalized as
14 opposed to really being an integral part of
15 everything we do.
16 So the idea is sort of like
17 someone could misinterpret this and say, well
18 okay, cultural competency, that's disparities.
19 You know, we address cultural competence
20 that's it in terms of our disparities efforts.
21 So again, this is an issue I think we should
22 try to avoid.

1 CO-CHAIR ANDRULIS: That's a point
2 back to NQF about distinguishing and making
3 sure that the issues are on race, culture and
4 language that we're taking up around cultural
5 competency, et cetera, are distinct from these
6 other ways of stratifying data on race,
7 ethnicity and language.
8 MEMBER CHIN: In other words I'm
9 here on disparities measures but we've been
10 talking about the past two days one critical
11 set of components, but there are sort of
12 critical components that were drawn on the
13 same level that maybe we can't sort of put
14 aside in terms of when others think about
15 disparities.
16 CO-CHAIR ANDRULIS: Thank you.
17 Romana, then Mara and then Donna and then
18 Francis.
19 MEMBER HASNAIN-WYNIA: So one of
20 the things that concerns me is, you know, I
21 don't know how to put it without sounding
22 negative, but this notion of kind of a message

1 glut and who actually adopts the measures that
2 we endorse and that NQF puts out.
3 So I worry that there's this
4 tension between kind of pushing the field and
5 wanting the field to go down a specific path
6 because we all believe in it and we all
7 believe equity should be part of everything we
8 do in health care.
9 But I also worry that if we have
10 too many measures and the measures have a lot
11 of questions still up in the air that we may
12 just get this kind of, oh that's another NQF
13 measure. So that's kind of one point that I
14 want to make.
15 So I'm a little bit concerned
16 about that and it was actually Allen's comment
17 that made me think of this because, Allen,
18 because of your comment about the gap in REL
19 and not having a measure, at this point, that
20 we've endorsed around data collection. And
21 those of you who know me know that I've done a
22 lot of work on data collection.

1 But I actually wonder is there a
2 gap? And how are we defining the gap? Is the
3 gap that NQF, that this committee, didn't
4 endorse a measure on race/ethnicity data
5 collection? Because from my point of view the
6 gap would be in that NQF isn't aligned with,
7 right now, kind of a little bit of a, you
8 know, maybe a mini wave of endorsements around
9 data collection.
10 So it's in the ACA, Meaningful
11 Use, Joint Commission, NCQA, it's in the
12 field. So yesterday when the AMA data
13 collection measure wasn't endorsed I was
14 thinking it's still going to happen. It's
15 still going to happen whether NQF endorses it
16 or not. That's something that's going to go
17 forward.
18 So to me, the question is do we
19 want to put out a set of measures where we are
20 really pushing the field because we know that
21 there's a gap and we know that the field isn't
22 quite going there yet. And we want to put out

1 a set of measures that are strong and do get
2 adopted versus saying, well there's a gap in
3 what we've endorsed through this Committee.
4 But from my vantage point I don't
5 see the gap. I only see it in, kind of in
6 this room, that we didn't endorse it therefore
7 NQF may come across as not being aligned with
8 what's being supported by the general policy
9 community and the accreditation world and so
10 forth.
11 So I'm thinking out loud so if I'm
12 kind of rambling, excuse me. But those are
13 the thoughts I'm having in terms -- And I'm
14 using data collection because I believe that
15 we do need the data as kind of a foundation.
16 So I'm a strong advocate of it, so I'm using
17 that as the example. So what's the balance
18 there? How are we defining a gap?
19 MEMBER JACOBS: Do you have a
20 proposal?
21 MEMBER HASNAIN-WYNIA: Do I have a
22 proposal to --

1 MEMBER JACOBS: Yes, how do define
2 the gap?
3 MEMBER HASNAIN-WYNIA: Well I
4 guess my question is are we defining the gap
5 narrowly within the context of our discussion
6 around a measure that we didn't endorse? Or
7 is there a general gap in the field around
8 activities not taking place that should be
9 taking place? So that's why I used data
10 collection. We didn't endorse a measure here
11 around data collection. But I think data
12 collection is going to move forward in the
13 field.
14 But then that's a different,
15 that's something that there may not be, you
16 know, kind of another push outside of what NQF
17 would endorse in the field. So maybe that's
18 kind of loosely right now that's what I'm
19 thinking.
20 MEMBER YOUDELMAN: It seems there
21 can be different categories of gaps. And this
22 wasn't going to be my comment but maybe it's

1 just fine. So one is stuff like data
2 collection or that NCQA has adopted, which
3 some of their stuff has actually made it into
4 their full accreditation for health plan. So
5 it exists, it's out there. It's just not
6 endorsed by NQF.
7 The second set then is sort of
8 what we talked about earlier, which is we now
9 endorse something for a hospital but there's a
10 gap because it's not for the broader provider
11 arena.
12 And then third, I think there's
13 categories of real gaps. So like I was
14 actually going to raise, we looked at cultural
15 competency in sort of a pretty narrow frame of
16 pretty much race/ethnicity language with a
17 little bit of literacy.
18 But disability, LGBT, is not
19 something here. And so that, to me, is
20 actually a pretty significant gap moving
21 forward. So I think there's different aspects
22 of it. To me I think I agree with you that if

1 it's already out then it's going to be done,
2 that's not a gap where I care as much about
3 focusing.
4 I'm more concerned about the ones
5 where it's either not hitting certain
6 providers that we need to hit, would tie to
7 the standards that we've developed. Or going
8 beyond that to other populations that we
9 haven't covered. But that's just my opinion.
10 MEMBER TING: Yes, let me add
11 gender to the mix.
12 CO-CHAIR ANDRULIS: Donna. And
13 then we'll go over to this side.
14 MEMBER WASHINGTON: Yes, I just
15 want to pick up on comments that a lot of
16 people made. So sort of tying it together
17 when Marsha was speaking, and now when
18 Romana's speaking, I'm just thinking about
19 sort of a framework for thinking about
20 disparities and maybe that's one way to sort
21 of couch both the NQF endorsed disparities
22 measures as well as our definition of gaps.

1 So first thinking about, sort of
2 commenting on what Romana just said, there's
3 other standards, which are sort of ideals, and
4 there are the measures. And so we all agree
5 data collection is essential.
6 And there are multiple standards
7 that support that. But it would be, if NQF
8 doesn't endorse, you know, we didn't endorse
9 the measure yesterday and who knows if there
10 are other measures out there.
11 I mean I think that that's one way
12 to sort of hone in on what at least the gap in
13 the measures are. So it's not saying that
14 it's not important, it's actually sort of
15 supporting one of your earlier comments about
16 not flooding the field with NQF endorsed
17 measures just because there is a gap or there
18 is a need to measure something to assure that
19 that standard is met.
20 So I think maybe in presenting
21 sort of the disparities measures or the
22 concept of measuring disparities as a whole it

1 might be useful to present this framework.
2 And then also, following up on
3 what Marshall said about the disparity, I
4 wonder is there a ranking of NQF endorsed
5 measures? Like some are considered more
6 important than others?
7 It just seems like the ones that
8 are measures that we'll be discussing this
9 afternoon that were endorsed for other
10 purposes, but that would be the ones that
11 would be stratified by race and ethnicity or
12 LEP or other indicators, because those are
13 high disparity measures, might be ones that
14 would be even more important to help plans and
15 others to adopt.
16 And so thinking about how to
17 present NQF disparities measures, I would
18 think about those things as sort of outcomes.
19 This is what we're trying to achieve. These
20 are sort of more proximate measures of health.
21 And then the cross-cutting things that we
22 discussed yesterday as like here are some of

1 the explanatory steps that lead to those
2 differences in outcomes so that people
3 understand you really need to look at both.
4 CO-CHAIR ANDRULIS: Do you want to
5 respond question about priorities?
6 DR. NISHIMI: Just in terms of
7 priorities, no. We don't do that ranking.
8 That's based on those who implement. So for
9 instance the group that Marshall mentioned,
10 the Measures Application Partnership, I don't
11 know if you're going to rank in the future,
12 but they make recommendations to CMS on what
13 measures to use in certain programs.
14 But within the performance
15 measures, the sheer endorsement process, there
16 is not a weighting or ranking of better or
17 worse. It's endorsed or not endorsed.
18 CO-CHAIR ANDRULIS: Now when I
19 hear the four comments that we just went
20 through I think it may come back again,
21 Marshall, to your idea of how we message what
22 we're actually putting out in the context of

1 saying, okay, there are gap, we recognize,
2 these are the measures that were submitted.
3 However, we also acknowledge that there are
4 these other very high priority areas that are
5 moving ahead.
6 Nonetheless, we are moving also
7 through these measures to advance the field,
8 yet again, that we acknowledge gaps in terms
9 of these measures that were submitted, but not
10 in terms of where the field is going.
11 There's that really important
12 balance to make sure that what we do here is
13 credible and relevant. Otherwise it may be
14 seen as kind of tangential to some of the
15 direction that the field's moving in.
16 Francis.
17 MEMBER LU: Yes, I put my flag up
18 several minutes ago, but I think many of the
19 comments have come up that I wanted to say
20 also. First of all the race/ethnicity data I
21 think is a bit of a gap in that people might
22 ask well why wasn't that part of the NQF

1 package of measures since this has been put
2 forward by a number of other groups mentioned
3 here, NCQA and the Class Standards and JCAHO
4 probably and other places.
5 So that gap I think will be fairly
6 glaring. People will ask why. And then the
7 issue about the missing groups, like the LGBT
8 and women and et cetera, disabilities. I
9 think that I understand the nature of our
10 focus here was focused on racial/ethnic
11 minorities but, as we all know, disparities go
12 beyond that particular lens, even though
13 that's perhaps the major focus of the federal
14 government, et cetera.
15 But again, as we know in the
16 disparity reports AHRQ they have been
17 reporting about disparities related to other
18 categories of cultural identities, such as the
19 ones we've just talked about.
20 So I don't know whether this is an
21 additional project, maybe, that we might to
22 recommend to NQF to focus on in the future or

1 maybe as part of this package of measures. I
2 think we need to explicitly say that this has
3 been the focus of this project and there are
4 disparities related to other cultural
5 variables that we would like the field to
6 think about or to put forward or something
7 along those lines.
8 So it's not inadvertently kind of
9 stated or understood that this is the be all
10 and end all. Do you see what I'm saying? I
11 think that be very important to make that
12 very, very clear.
13 And then the final thing was the
14 issue of applicability of our measures. You
15 know these were tested in certain systems but
16 to what extent, is this kind of generalizable
17 to all healthcare systems, you know, is that
18 really clear? And should that be more
19 explicitly stated? I don't know, I just put
20 that out there.
21 CO-CHAIR ANDRULIS: Thank you,
22 Francis. Ernie.

1 MEMBER MOY: I had some
2 reflections on the comments that Marshall
3 made. And I do think it's important to have
4 some kind of topology for disparities as it
5 were, so that we don't get mixed up in terms
6 of our measures. And I think what I see is
7 something that analogous to like the Andersen-
8 Aday model, because you kind of have
9 potential.
10 Basically you have potential
11 access and realized access. Potential access
12 like insurance and stuff like that. And then
13 realized access is actually getting the care
14 that you need. And I think disparities is
15 something along that line as well.
16 So we have potential risk factors
17 for disparities, which is what the focus of
18 this conversation has been, like literacy and
19 not having culturally competent providers.
20 But then there's a whole realm of realized
21 disparities which is actually looking at
22 clinical measures and seeing that there

1 actually are differences across race and
2 ethnicity.
3 And I am concerned that with those
4 emphasis being placed on these disparities
5 risk factors that someone can say, oh well we
6 did the survey of cultural competency so we're
7 not going to do the hard thing of taking our
8 clinical measures and stratifying and looking
9 at the realized disparities.
10 And so I think there's some value
11 to creating some kind of topology and saying
12 you should actually look at both. You should
13 look at some risk factors. You should look at
14 the actual realized disparities because that's
15 important as well. So I put that out there.
16 On data collection I wish that we
17 had a data collection and race/ethnicity
18 measure yesterday, because I think it's really
19 important. But then listening to the
20 conversation today I think I appreciate that
21 if we put out a recommendation just about
22 collecting race/ethnicity and not about all

1 the other components of culture, then that
2 might not be serving things well either,
3 because there are a lot of other things that
4 are important for cultural competency beyond
5 race and ethnicity.
6 CO-CHAIR ANDRULIS: Colette, then
7 Mary.
8 MEMBER EDWARDS: My comments kind
9 of tie into, probably the most with what
10 Marshall had said, and Romana, in talking
11 about messaging and also the concern about
12 having a lot of measures out there that are
13 basically doing the same thing.
14 And I remember in the very first
15 face-to-face meeting we talked about the issue
16 of harmonization and having messaging to the
17 people who are developing that they should be
18 looking to see what other people were doing so
19 we didn't get into a situation of them
20 basically reinventing the wheel. And having a
21 lot of measures out there as opposed to people
22 focusing on new things or actually getting the

1 work done.

2 So I don't know how strongly that
3 actually gets communicated. I just don't
4 remember, to the people who are developing
5 where that point is strongly made in terms of
6 looking to see what people have already done
7 that would basically address what they may be
8 developing, because then there can be some
9 statement in the messaging about
10 harmonization. So that would kind of address
11 what Francis was saying about it being a
12 glaring gap.

13 It's not a glaring gap because we
14 recognize that it's being covered someplace
15 else and would also message to the people who
16 are developing what we're really interested in
17 is something new, different or focusing on
18 getting things done as opposed to a replay,
19 with a tweak, of something that's already out
20 there.

21 MS. MCELVEEN: So I think we're
22 starting to get closer to how do we do it is

1 the question. And is there a way to identify
2 a document, some type of introductory
3 something, that includes the breadth of this
4 conversation. They're all important points.
5 And we obviously can't include everyone's
6 standards in an NQF document. But there seems
7 to be a need to have some capsulization of the
8 various touch points.
9 I mean, there's the Office of
10 Minority Health stuff. There's the stuff from
11 Joint Commission, there's the Class Standard.
12 So there are a variety of players who have
13 made contributions to look at cultural
14 competence, cultural diversity and can we cite
15 that richness of that body of work some kind
16 of way, almost in its entirety. I don't know
17 that we ever get to the entirety, so that
18 indeed we have given voice to recognizing that
19 there are lots of players at this table.
20 CO-CHAIR ANDRULIS: So yes,
21 Francis and I sit on the Class Group as others
22 have, and this issue has come up in Class as

1 well, that okay so you're doing all this work
2 but how do you contextualize this in some way
3 that it's relevant. That people get a sense
4 of oh, I see how ths fits. I see how.
5 So it's the roadmap or at least a
6 sense of relevance, to me. And I think it may
7 be, as it is that a lot of these reports kind
8 of important and incumbent maybe for us to
9 take a look at an outline of what would be put
10 into such a document.
11 DR. NISHIMI: I just want to make
12 clear that NQF has, and I think it's somewhat
13 new and Elisa can confirm, a standardized
14 report format, which is not to say that we
15 couldn't reference these things and they're
16 all in line now and link to them.
17 But if you're looking sort of for
18 a treatise that reviews all this stuff and
19 actually includes it in the body of the
20 report, my sense is that the report formats
21 don't permit that.
22 CO-CHAIR ANDRULIS: Do the format

1 reports allow input into, within the context
2 of the different segments of that report
3 format, so --
4 DR. NISHIMI: I mean you will
5 review this, but what I heard from you all was
6 sort of a call for a section describing this
7 and perhaps listing them and cross-walking
8 them, those kinds of things. That is not the
9 kind of thing that fits within the formats.
10 Obviously we could reference the work of
11 others and provide links to that. But that's
12 the way the reports get shake out here.
13 CO-CHAIR ANDRULIS: Mara.
14 MEMBER YOUDELMAN: I want to build
15 on that with a question or a suggestion. And
16 I think one way to sort of address some of
17 this discussion is to make sure that the
18 report brings back the previously endorsed
19 measure on data collection. And to say it's
20 already been endorsed. Here it is.
21 DR. NISHIMI: Right.
22 MEMBER YOUDELMAN: It's not being

1 up for approval now, but that it set the stage
2 for this work, to some degree, and to really
3 show that history and to make that connection.
4 DR. NISHIMI: There is a section
5 on related NQF endorsed. And so that would
6 have had a basis in that.
7 MEMBER YOUDELMAN: I mean I think
8 that is the point is if therefore, and the
9 main report references to it, then I think we
10 can capture some of this. And then, of
11 course, if there's an away to, either in the
12 section talking about the previously endorsed
13 measures, or an appendix to just get to some
14 of these pieces, I think that would be
15 helpful.
16 I guess my other suggestions are,
17 is I don't know if it is worth a conversation
18 with NCQA to ask them about submitting some or
19 all of the multi cultural healthcare standards
20 that they have.
21 Since we have to have a
22 conversation about the RAND standard, which

1 was submitted late, it might be an opportunity
2 to have that conversation with them and say
3 are there any pieces of this puzzle that you
4 might want to submit and it becomes a
5 secondary piece, if that's allowable. Or at
6 least to just find out why they chose not to.
7 Was it affirmative for some reason, or
8 whatever.
9 And then the last piece I think
10 this is picking up on what Marshall and what
11 Ernie were saying is, is there a way going
12 forward that as new measures are proposed, or
13 then come up for renewal at the end of their
14 initial cycle, to put in part of that process
15 an evaluation of disparity sensitivity. And
16 to really build it in to the entire NQF
17 process as opposed to what we're doing now,
18 which is add-on measures.
19 And there's still a reason for
20 add-on measures. But I think what we're
21 really sort of saying is it should be based
22 in, it should be part of this process.

1 DR. NISHIMI: And it is now. It
2 just wasn't before. For instance in the
3 cardiac care project, several measures that
4 were up for re-review came in and they didn't
5 have the section on stratification by race and
6 ethnicity and disparities in them and they
7 just sent them back to the developer and said,
8 yo', these have been endorsed for six years
9 now. You either give us this data or we don't
10 review it.
11 So it is baked in now. It's just
12 that we had such, obviously, a huge part of
13 the portfolio where it wasn't initially baked
14 into the submission.
15 CO-CHAIR ANDRULIS: Okay, Liz.
16 MEMBER JACOBS: I just want to go
17 back to something that Francis and I think
18 Colette brought this up. My understanding of
19 this process is that we weren't told that we
20 just had to focus on racial/ethnic and
21 linguistic disparities.
22 I mean if we think there's a gap

1 in issues around LGBT and other issues I think
2 we should actually bring those up. I mean, we
3 don't have good measures but that's still part
4 of disparities and cultural competency. So I
5 would like to see us not leave that off the
6 table.
7 DR. NISHIMI: Anything else?
8 CO-CHAIR ANDRULIS: Other
9 comments? Questions, thoughts?
10 DR. NISHIMI: Very excellent
11 discussion, thank you. You want to go to
12 Taroon?
13 MS. MCELVEEN: Thank you guys. So
14 now we are going to have a discussion with the
15 committee, as Dennis had mentioned, around
16 community level factors for addressing risk
17 adjustment. And my colleague, Taroon, is here
18 to start that discussion with the group.
19 MR. AMIN: Great. I know that
20 Helen wanted to be here, so she'll be here in
21 probably ten minutes. She's just finishing up
22 a board discussion. So my name Taroon Amin.

1 I am a senior director here at NQF. I am
2 working with Alexis Forman, who's actually in
3 the back here, looking at an expedited review
4 of all cause hospital readmissions.
5 We are in the process of actually
6 voting for two measures that were recommended
7 for endorsement. One measure that was looking
8 at a hospital level unit of analysis. And
9 another at the health plan unit of analysis.
10 And while the specific elements of
11 the measure are probably not as relevant for
12 the discussion today I wanted to give you a
13 little bit of the context of the nature of
14 what I'd like your reflections on today.
15 So the measure that we were
16 looking at is a hospital level risk
17 standardized rate for unplanned, all cause,
18 hospital readmission following any eligible
19 admission within 30 days of hospital
20 discharge. And it was tested in All Payer
21 looking at ages 18 and older. So it includes
22 Medicare and 18 and older.

1 During the evaluation we received
2 a great deal of comments from the hospital,
3 particularly from the hospital community, but
4 from a broad stakeholder perspective, that the
5 particular outcome of interest in this case,
6 hospital all cause readmission, had very much
7 to do with the socioeconomic status of the
8 patients under evaluation.
9 So the socioeconomic status of the
10 patients had a lot to do with the nature of
11 the readmission and the rate of readmission.
12 And the hospitals that disproportionately
13 treated this population would be at risk of a
14 lower performance based on what many
15 considered to be community level factors
16 rather than hospital level factors.
17 And since the hospital level was
18 the unit of analysis this raised a
19 considerable amount of concern and comments
20 for the broader community.
21 The steering committee considered
22 these comments but ultimately decided that

1 adjustments of SES and a risk adjustment model
2 was inappropriate, mainly because of the
3 guidance from this committee and the guidance
4 from NQF, in particular, on this issue of race
5 and SES that including SES variables and a
6 risk adjustment model would inappropriately
7 assume two different standards of care.
8 However, they struggled with
9 guidance on what our potential guiding
10 principles going forward for this type of
11 concern, considering that emerging research
12 and previous existing research actually
13 demonstrates quite a bit of a relationship
14 between race and SES and hospital
15 readmissions, for measures that are currently
16 endorsed.
17 This measure, looking at the
18 previous measures that were endorsed were
19 condition specific, this measure would be all
20 cause hospital readmission. So presumably,
21 from these commenters, the effect would be
22 greater.

1 So the Committee ultimately
2 decided to essentially look forward into the
3 future to consider potential hospital level
4 adjusters or potentially community level
5 adjusters that could be tested and used for
6 this type of application.
7 That was sort of a consideration
8 moving forward. That would be one area that
9 we would kind of look to this group for some
10 area of reflection of what would be the effect
11 of using hospital level or community level
12 adjusters in looking at risk adjustment for
13 this particular cause.
14 The other recommendation that came
15 from the Steering Committee, which is more in
16 the realm of reporting, but also begs a little
17 bit of discussion, is requesting, in display
18 of this data, that hospitals be reported
19 against like comparison groups. And one
20 particular example was using disproportionate
21 tier hospitals and comparing them against each
22 other for this particular application.

1 So those are two particular areas
2 that we'd look for some reflection from this
3 group, particularly because of the high stakes
4 natures of this area of measurement for use in
5 public accountability and, likely, payment
6 programs in the future for hospitals. This
7 was one area that we wanted to get some
8 thoughts from this group.
9 And there may be more that Helen
10 would like to add to this discussion but I'll
11 leave it there and submit that to the group
12 for discussion.
13 CO-CHAIR ANDRULIS: Yes, this is a
14 long-standing issue. This has come in context
15 of severity of illness discussions decades
16 ago. I remember this in the 80s being an
17 issue, that -- I've got to get out the
18 Geritol.
19 (Laughter)
20 CO-CHAIR ANDRULIS: I know from a
21 public hospital perspective that this was a
22 very sore point. That there were issues

1 around referrals that they had responsibility
2 of that. And sometimes they had no control
3 over, in terms of, like, ties to long-term
4 care facilities.
5 And there are all sorts of
6 anecdotes about some of the long-term care
7 facilities because of their contractual
8 obligations, were actually sent back to die in
9 the hospital after they had been discharged.
10 They were readmitted in a terminal condition
11 and then, because the nursing home didn't want
12 responsibility for that person's passing.
13 So it's treading in very worn, but
14 very sore, territory in a lot of ways. And
15 stratification by hospital type might be one
16 of the points really to consider carefully in
17 moving ahead. Ernie then Donna and then
18 Elizabeth.
19 MEMBER MOY: Yes, I know old
20 conversation. You have to risk adjust because
21 the facilities you can use are too different.
22 You don't want to risk adjust in a way that

1 you lose the information, so I think the
2 traditional approach is stratification. Your
3 suggestion of stratifying by hospital
4 characteristics is reasonable but you might
5 also want to stratify by community
6 characteristics so you're comparing like
7 communities.
8 MEMBER WASHINGTON: Well I
9 couldn't have said it better.
10 CO-CHAIR ANDRULIS: Liz, then
11 Jerry, then Marshall.
12 MEMBER JACOBS: I actually say if
13 you do this you let hospitals off the hook.
14 Hospitals should figure out how to provide the
15 same quality of care to those patients. And I
16 would say a lot of that readmission does not
17 have to do with the individual or the
18 community, it has to do with the way --
19 Because I worked in a public hospital for 12
20 years.
21 And we don't have good services
22 for serving these communities and that if we

1 risk adjust we're not forcing them to actually
2 address the issues, which is that they're
3 providing lower quality fo care to these
4 patients. So I actually say it lets people
5 off the hook.
6 And what we talked about in our
7 first session, when Joe and who else came to
8 present the paper? Thank you. We talked
9 about doing it two ways, showing the
10 unstratified and the stratified.
11 I mean how you would decide what
12 to do on that, but honestly if we're going to
13 stratify and we're going to risk adjust this
14 stuff away no one's going to do anything about
15 this problem, which is that if you're Black,
16 if you're poor, if you don't speak English,
17 you've got worse care.
18 And it is somewhat about community
19 factors, but it also has to do with the
20 hospital and the quality of care they receive.
21 And I know because I practiced in that
22 setting for 14 years.

1 CO-CHAIR ANDRULIS: I think Liz
2 raises a very good point. I would say also
3 though that because you risk adjust doesn't
4 necessarily mean that you're avoiding the
5 issue. You're just acknowledging the
6 circumstances.
7 Acknowledging the circumstances to
8 the extent that they need also to be
9 addressed, not to say that they're risk
10 adjusted away. You know, this is a long
11 standing issue that is both infrastructurally
12 and issue in some of the safety net
13 institutions for example. But at the same
14 time it's a broader fiscal -- Anyway. And
15 organizationally.
16 MEMBER WASHINGTON: Just to
17 clarify. I wasn't advocating for risk
18 adjustment, I was advocating for stratifying.
19 I think that it's important to present both
20 the overall unadjusted as well as the
21 stratified results.
22 The problem with just presenting

1 the overall results alone, without
2 stratifying, I mean in essence sort of risk
3 adjusting by stratification, is that hospitals
4 that do not have a disproportionate share of
5 either vulnerable patients, or other patients
6 with characteristics associated with some poor
7 quality outcomes, are essentially off the hook
8 and rewarded.
9 So I would be concerned about sort
10 of the reverse problem. Not so much that
11 you're holding minority serving institutions
12 accountable, but more so that others get
13 inappropriately rewarded. Particularly if
14 they're in settings where performance is tied
15 to reimbursement. So I would definitely do
16 both.
17 CO-CHAIR ANDRULIS: Yes, right.
18 So you run into the same issue around paper
19 performance. Kind of trending you want to
20 move towards those who will make you look
21 better.
22 MEMBER WASHINGTON: Right.

1 CO-CHAIR ANDRULIS: And so it's a
2 complex issue.
3 MEMBER JACOBS: I'm sorry, you're
4 saying that this would lead to like cherry
5 picking or people, explain to me a little bit
6 more about how you feel --
7 MEMBER WASHINGTON: So I'm
8 thinking about healthcare systems, for
9 example, sub-pay for performance. If you
10 don't stratify, if you just look at overall
11 results, without some sort of accounting for
12 differences in patient populations, then you
13 may inappropriately reward hospitals that are
14 better performing because of their patients or
15 community factors.
16 MEMBER JACOBS: I'd like to
17 respond to that though. Because the issue of
18 these community factors are totally confounded
19 by who are the hospitals taking care of them
20 too? What is it, something like 80 percent of
21 African Americans are seen in 20 percent of
22 the hospitals, something like that. And those

1 20 percent of hospitals are disproportionately
2 low performing hospitals.
3 And, like I say, it's like I think
4 that people are sort of blaming the patient.
5 And I think we're the healthcare system. Our
6 job is to actually do better for them. So I'm
7 a little bit concerned about, yes, there are
8 these community factors but the hospitals
9 should, I see we don't want to penalize them,
10 I see what you're saying. I think we had this
11 discussion about actually paying people for
12 more complex patients. Maybe we should
13 reimburse these hospitals higher.
14 But I also think that I just don't
15 want to recommend something that would promote
16 the status quo, which is that these patients,
17 who also suffer for these community factors
18 also tend to go to these hospitals that are
19 very low performing. And we're not holding
20 them accountable for that low performance.
21 CO-CHAIR ANDRULIS: Okay, one
22 more, I want to get other folks involved with

1 this.

2 MEMBER WASHINGTON: So in an ideal

3 world then you would actually use that to

4 target resources toward low performing

5 hospitals?

6 MEMBER JACOBS: Yes.

7 MEMBER WASHINGTON: Okay, so to

8 use the VA healthcare system as an example,

9 then they have a very complicated process for

10 categorizing patients into different risk

11 categories. And then hospitals are reimbursed

12 based on a combination of performance and

13 patient mix.

14 And so, for example, the patient

15 mix, low income patients, they get reimbursed

16 at a higher rate, for example, than higher

17 income patients. Or homeless patients, they

18 get reimbursed at an even higher rate.

19 And so that sort of levels the

20 playing field. And then you can look at

21 performance without that risk adjustment. So

22 maybe that's too complicated to advocate in

1 other healthcare settings, but that's an
2 example of how you can sort of stratify in
3 direct reimbursement but without risk
4 adjusting the results.
5 CO-CHAIR ANDRULIS: Marshall, then
6 Kevin and then, Jerry you're next. Sorry
7 Jerry, Kevin, Marshall. I know I'll get to
8 Mara and Grace.
9 MEMBER JOHNSON: It's hard to know
10 where to begin here because I think what we're
11 really talking about is fixing the entire
12 healthcare system of the United States, which
13 is a little bit complex.
14 (Laughter)
15 MEMBER JOHNSON: I really do think
16 that's what we're talking about. But I've
17 participated in a number of discussions about
18 this all cause readmission and I'd start by
19 saying that, I mean, I do endorse all cause
20 versus kind of disease matched readmissions,
21 which might allow hospitals to game systems,
22 particularly with older adults where most of

1 these admissions and discharges occur.
2 So somebody comes in with heart
3 failure, they get readmitted for some other
4 reason, for a fall, but actually they went out
5 of the hospital unstable. And hospitals and
6 systems need to address the whole person, not
7 just part. So that's where the all cause
8 comes in. I do endorse that.
9 And I do think that health systems
10 and health plans and hospitals have a
11 responsibility have a responsibility for a
12 continuum of care, including outpatient care
13 and the whole transitions piece. And if some
14 persons are in communities that are low
15 resource, compared to others, then health
16 systems have a responsibility to those persons
17 too.
18 I mean certainly the public, and
19 we of the nation, can't ignore those persons.
20 And they need care. They just are going to
21 require different kinds of resources. To a
22 large extent I think we're talking about a

1 resource issue and how do we fund persons who
2 require more resources for care than do
3 others.
4 I'm in favor of not risk adjusting
5 but I mean stratify and take a look at the
6 persons that systems and hospitals care for.
7 The community level versus a patient-centered
8 approach, saying what kind of resources do I
9 need or someone else needs, versus the
10 community that I come from, I don't know.
11 I'm grappling with the best way to
12 define community level in 2012 in relation to
13 any particular hospital as a geographical
14 proximity to where somebody lives.
15 And I find that extremely complex
16 when I think about, at least, the city where I
17 come from, from Philadelphia. And the
18 neighborhoods that are close to the hospital
19 versus a little bit further away versus
20 farther away and what's the community and
21 what's not.
22 So let's stratify, we have to do

1 it. I think to a large extent it's really a
2 funding issue and how do we pay for persons
3 and to provide the resources that are needed?
4 CO-CHAIR ANDRULIS: I think,
5 Kevin, you've had your tent up. And then Mara
6 and Chris.
7 MEMBER FISCELLA: One way of
8 looking at disparities is to think about a
9 mismatch between the needs of the individual
10 and the resources of the system to respond to
11 those needs and to look at that in a variety
12 of ways, what are the financial resources, but
13 obviously it's culture and linguistic and so
14 on.
15 And the better that match
16 potentially the smaller those disparities.
17 The greater that mismatch the bigger the
18 disparities. And that's the problem that's
19 been alluded to is that people who are more
20 disadvantaged tend to utilize providers,
21 whether it's physicians or hospitals, that
22 have fewer resources.

1 And so this problem is real and
2 Medicare is, I guess, getting ready to deny
3 payment for people who are readmitted for
4 certain conditions within 30 days and there's
5 data out there to suggest that hospitals that
6 disproportionately serve African Americans and
7 low income patients will be disproportionately
8 penalized which will worse that mismatch
9 between resources and providers.
10 And I think stratification offers
11 a reasonable compromise in terms of still
12 holding groups accountable, but accountable
13 with groups that have comparable resources.
14 It's not fair to compare one hospital who
15 really doesn't have the resources for a highly
16 developed quality improvement program with
17 those that do.
18 And I think Rachel Werner has
19 shown that using national data, so we have
20 good empirical data on that.
21 The other factor that we need to
22 keep in mind is that factors such as race are

1 proxies for worse worth health through
2 weathering or accumulative disadvantage over
3 the entire life span, which means, in many
4 cases, that you're going to see racial
5 differences in health care. In part as a
6 result of those factors that are not fully
7 accounted for by ICD-9 diagnosis adjustment,
8 including greater likelihood of being
9 readmitted for heart failure at a younger age
10 or so on and so forth.
11 So I think there does have to be a
12 balance, otherwise we're just going to be
13 tipping that mismatch between needs and
14 resources in the wrong direction.
15 CO-CHAIR ANDRULIS: I'm going to
16 suggest that we kind of focus more on these,
17 what you started down the path more directly
18 on, it's community level factors that might
19 play. It actually starts the play in the
20 world of social determinates as well. So,
21 Marshall.
22 MEMBER CHIN: So some ways we're

1 recapping sort of the diversity discussion we
2 had, I think it was at our first meeting, when
3 Joe and Joel Weissman came. And in some ways
4 it gets to an issue of a change in perhaps
5 what NQF should do. You know, if you take one
6 extreme of well we're just going to sort of
7 put the stamp of approval on different
8 performance measures as NQF approves them as
9 one, you know, far end.

10 Something in the middle in terms
11 of like stratification where it's, well, a
12 mini step in terms of how you use the data.
13 Well use the data but then stratify.

14 I think a third way, which I
15 think, again, Joe and Joel nicely did in their
16 article, and I think probably I would
17 recommend we think strongly about doing here
18 also is, basically the next step in terms of
19 recommendation that accounts for the
20 complexity that Donna and Jerry and Liz were
21 talking about.

22 So if this is going to be used for

1 accountability purposes, these measures,
2 besides stratification, I mean there are other
3 things to take into account. So for example
4 do you reward based upon absolute attainment
5 versus relative improvement. The issue of if
6 you have under resource setting is there some
7 system that Donna mentioned there are others
8 where additional resources go to the under-
9 resourced setting.
10 You know it starts getting into a
11 little bit of policy but I think if you sort
12 of say the issue of well, here's what we want
13 to avoid, you know, the cherry picking or the
14 making things worse in a situation, we're not
15 advocating a specific answer but here are
16 examples and I think they're papered to this
17 well. You know, here are examples of ways
18 that people have built into the system ways to
19 safeguard against that.
20 To me it's more honest in terms of
21 addressing the complexity. And stratification
22 is a good first step but this goes beyond it.

1 And in some ways this may not be different
2 than other issues where people are saying,
3 well you have an issue of like under-resourced
4 settings, this is not a new issue.
5 But especially if it's the means
6 for accountability purposes, and you mentioned
7 that once the measure is approved it could be
8 used for any purpose. In some ways if that's
9 not addressed that's probably equally bad as a
10 risk you may feel in terms of putting your
11 neck out in terms of starting a little more
12 policy oriented.
13 DR. BURSTIN: I apologize for
14 being late, got stuck on a board call. I
15 think what we're really saying is we
16 completely concur with what the paper said.
17 The paper said don't risk adjust based on race
18 and ethnicity. And we've stood our ground on
19 that and concur with that.
20 I think what came up recently as
21 part of this discussion, and it's really a
22 question if you're not so much about the

1 readmission measure before them, and Taroon
2 told you the recommendation was like hospitals
3 should be reported with like hospitals, very
4 much along the lines of what you're saying, is
5 really is there more work to be done here to
6 understand if there is an opportunity to think
7 about what Joel and Joe actually put in the
8 paper, is when there are indications of when
9 there is a community level effect here is
10 there consideration of what those community
11 level factors could actually be put into a
12 model. Because what we're really talking
13 about is the measure itself.
14 A lot of those other things you
15 just mentioned, Marshall, and others as well,
16 are kind of outside the purview of the
17 endorsement process. You know, CMS can make a
18 lot of decisions about payment, others can
19 make recommendations. The question is on the
20 measure itself. Would there be, we continue
21 to believe you shouldn't adjust for individual
22 patient level factors on race, ethnicity, SES,

1 et cetera. The question is is it worth
2 thinking about what Joel and Joe raised about
3 would you potentially adjust for the community
4 level capacity to take those patients and
5 really be able to help them?
6 In the case of readmissions it's
7 especially important, just that if they are at
8 community capacity for followup it may, in the
9 measure at least being currently being used
10 for accountability at the hospital level, how
11 do you sort of factor that in?
12 I really just asking because we're
13 trying to think about should we do more work
14 here to really help a group like you thinking
15 through what are those community factors. Are
16 they things you would stratify on? Are they
17 things you would adjust for? What's the
18 science of even knowing yet of what those
19 things would be?
20 MEMBER CHIN: But how is it really
21 different in some ways? I mean we talk about
22 individual factors but the community level

1 factors to me it seems like it'd be the same
2 issues that Liz and Jerry and Donna have
3 raised of, I guess, the issues of resource or
4 as history, as Kim was saying, so that
5 whatever else you call it, an individual race
6 variable or an individual measure of community
7 deprivation, say.
8 It's the same issue right? So you
9 could come up with a better methodology for
10 measuring those, but I think in some ways it's
11 just skirting the issue.
12 CO-CHAIR ANDRULIS: You opened up
13 a can of beans here. So let's see if I can
14 get this right. Mara and then Colette and
15 Mary. Now let's just go that far and then
16 we'll continue on.
17 MEMBER YOUDELMAN: And I'm still
18 trying to sort that out. But I guess part of
19 what my question is, and so this may point to
20 the need for more work, is how much is the
21 hospital responsible for helping improve the
22 community options versus just taking it as it

1 comes and therefore you absolve the hospital
2 from some responsibility.
3 And I think that's a question that
4 I'd like to see more delving into because at
5 least with the ACA requirement on the hospital
6 required conditions they do recognize that
7 language might be a factor. And so they are
8 willing to give some money to help with
9 interpreting and translation at discharge if
10 that's going to help prevent hospital
11 readmissions just because of language
12 barriers.
13 But if you don't have a rehab
14 center or a nursing home where language
15 services are in place then discharging that
16 person with language services isn't going to
17 help if the person then needs the community
18 supports.
19 But that sort of goes into the how
20 much of the responsibility is on hospital to
21 help identify and develop the community
22 supports that will improve its readmission

1 rates versus just you sort of say okay,
2 there's nothing in this community for whatever
3 reason.
4 So that's a piece I guess I'd like
5 to see more focus on in figuring out how you
6 develop it and is it staff at the hospital,
7 resources in the community, partnerships, et
8 cetera, et cetera.
9 CO-CHAIR ANDRULIS: Colette.
10 MEMBER EDWARDS: So I guess I
11 would say, kind of going back to what Donna
12 had laid out, which I think is also in
13 essence, I don't know if I would go as
14 strongly to phrase it as a recommendation, but
15 really was a recommendation from Joe and Joel
16 in terms of the differential reimbursement
17 that I think that it may be outside our
18 purview but if it's not I feel very strongly
19 that NQF, with its heft and reputation, needs
20 to make a statement in that direction because
21 this is at a critical point where lots of
22 people are making lots of decisions about

1 reimbursement schema.

2 And if we don't a stand now the

3 people who are in a poor position, it's only

4 going to accelerate very, very quickly and get

5 out of control. And I think the opportunity

6 is, right now, to put that out there for

7 consideration by the people who are making

8 determinations.

9 And kind of to Mara's point, the

10 issue of the Medicare not reimbursing for

11 certain things has had an impact in terms of

12 hospitals with resources doing something about

13 what they're doing internally plus also what

14 happens after the person is discharged and

15 what's going on in the community, because

16 they're the ones that then lose money.

17 So follow the money trail is what

18 I'm saying. And we need to make a statement

19 about it now.

20 CO-CHAIR ANDRULIS: Mary.

21 MS. MCELVEEN: So is it that we

22 need measures that hold whatever institution,

1 no matter where they're located, responsible
2 for getting maximal patient outcomes and
3 providing maximal care? And if that's the
4 standard how do we measure that, no matter
5 who's paying for it?
6 It is almost like you need a
7 navigator, every patient needs a navigator, to
8 help them get the best care in whatever
9 facility. Short of being able to do that are
10 there ways to create measures that evaluate
11 that so is it quality of life and quality and
12 care?
13 And I don't know the answer but
14 somehow if you can come up with a way to
15 evaluate both of those things I think you
16 change outcomes. And one of the ways to
17 possibly consider is looking at what's
18 currently in the literature in terms of
19 looking at evidence based outcomes. So that's
20 part of where the science is in terms of
21 quality.
22 CO-CHAIR ANDRULIS: Dawn.

1 MEMBER FITZGERALD: My mind's
2 actually a little spinning so it probably
3 won't be very coherent, but this is
4 interesting because we've been doing a lot of
5 research in our own state in looking at
6 readmission rates across Tennessee. We've
7 done analyses for each of what we call our
8 metropolitan areas.
9 And it's ironic because the
10 assumptions that we went into a priori about
11 what we would find in terms of high
12 readmission rates was not proven true. In
13 fact, the lowest rates of readmission in our
14 state are in Memphis, which has the lowest
15 SES, highest racial diversity in the state.
16 And the outcome has actually been
17 that where the high readmission rates occur
18 are in largely rural, small referral hospitals
19 that generally have some sort of a
20 relationship with a hub hospital like regional
21 hospitals that connect to Vanderbilt for
22 example. Or Upper East Tennessee hospitals

1 that have a connection down to the university
2 hospitals.
3 So I guess my point is is that
4 we're making assumptions about the kinds of
5 community based adjustors or considerations
6 that we need to take in place. And the fact
7 is if you look, even in the state of
8 Tennessee, the answer to what the community
9 based issue is is different.
10 In Memphis we have a large pocket
11 and volume of high repeat utilizers who are,
12 you know, it's less than five percent of the
13 population but over 25 percent of the costs.
14 In East Tennessee it's a more broad based
15 network, it's not largely affiliated with any
16 particular zip code or geography, it's just a
17 lot of people that have no other resources
18 available to them but a hospital care setting.
19 So I don't know what to say other
20 than when you start to drill down and think
21 about things from a regional perspective the
22 easy answers that we sit around and talk about

1 here aren't what happens when you go down to a
2 regional level and start drilling into the
3 data and hypothesizing what the true causes
4 are.
5 And I mean that was sort of this
6 lesson learned about sitting back and armchair
7 quarterbacking what the important issues are
8 without actually looking at it from a
9 community's perspective.
10 CO-CHAIR ANDRULIS: Ernie, then
11 Romana and Grace and Jerry.
12 MEMBER MOY: I agree that the core
13 issues, I think what you're trying to actually
14 measure with the readmission, and I think that
15 what we're interested in measuring from a
16 quality perspective is the stuff that the
17 hospital did during the hospitalization, and
18 after the hospitalization, and how that
19 contributed to the readmission rate.
20 And we're not interested in the
21 other major driver, which is the underlying
22 community admission rates. And so I would

1 suggest, if you want to adjust out these
2 community effects, maybe you can just adjust
3 for the underlying community rate of
4 admission. And then that would isolate this
5 kind of quality contribution of the actual
6 hospital.
7 MEMBER ANDRULIS: Romana, Grace.
8 MEMBER HASNAIN-WYNIA: Right, and
9 I'll be the first to admit that this whole
10 public hospital setting is very, very foreign
11 to my world.
12 But I wonder whether there's going
13 to be any value in looking at some of the best
14 practices facilities or systems, like the New
15 York City Health and Hospital Corporation or
16 the Jackson County Health Systems, that have
17 done really well in terms of quality and yet
18 practice in a very diverse, urban,
19 disadvantaged community.
20 And what are their quality drivers
21 that lower some of these readmission rates,
22 and see whether there are factors that can be

1 teased out in terms of thinking what to
2 incentivize and adjust, just a thought.
3 CO-CHAIR ANDRULIS: Commonwealth
4 Fund has had high performing health systems
5 effort for a long time that's targeted safety
6 net organizations.
7 And what ends up happening a lot
8 of times, programs like Denver Health have
9 come out as a leading safety net organization.
10 What ends up happening a lot of times though
11 with these kinds of promising or model
12 programs is that when you go to replicate them
13 there's Denver Health and then there's Denver
14 Health.
15 And it's been hard to tease out
16 those broadly applicable opportunities. And I
17 think it may get back to what you talked,
18 Dawn, you take it down to the individual level
19 and the circumstances, the sociopolitical
20 community circumstances just are hard to
21 match. But nonetheless, there are efforts
22 that continue to look at and see if you can

1 tease out these promising aspects.
2 MEMBER JOHNSON: I might be able
3 to understand what the options are a little
4 better if we talk more directly to what some
5 of these community level factors may be that
6 we're even considering.
7 For example, some things that come
8 to mind are zip code or census track. Or it
9 could be resources within a given geographical
10 area, such as primary care doctors or other
11 providers, that sort of thing, but just what
12 these community level factors are that we're
13 talking about.
14 Persons have tried to measure
15 social cohesion. You know what, just which
16 ones we're talking about. But what strikes me
17 is that, in contrast to the community level
18 factors, when we go beyond the individual
19 there's the family.
20 What about family in community
21 level factors? When I think about
22 readmissions, just in a very practical sense,

1 the question is, is the person who leaves the
2 hospital living alone. Is there really a
3 social network around that person, like
4 someone in the house if it's a frail older
5 adult.
6 And then the word family is
7 culturally laden too. Families mean different
8 things. Depending upon the notion of a family
9 back in the 1960s, based upon television and
10 for those who remember Ozzie and Harriet, that
11 kind of notion of the family is probably a
12 myth compared to family that I know of and try
13 to work with in West and Southwest
14 Philadelphia.
15 But, nevertheless, I would think
16 that family factors probably have more of a
17 bearing than community level factors on
18 readmission.
19 CO-CHAIR ANDRULIS: Yes, we worked
20 on a project where we actually established
21 just a crude couple of indices, one a social
22 depravation index and another one a child

1 well-being index, where we just combined
2 available data from census and other sources
3 and looked at those in the context of the way
4 cities and suburbs were changing over time.
5 And there was a lot of face
6 validity to what we'd come up with as you
7 looked at the cohesive aspects of those
8 elements within the index, and then using them
9 as a way to get a sense of what are the
10 support systems and the status of certain
11 conditions within communities that would then
12 have implications for health and well-being.
13 Liz?
14 MEMBER JACOBS: I'm just going to
15 express one concern about this adjustment for
16 the community context. One, I think someone
17 else brought this up earlier, I think it is
18 really hard to actually define what community
19 is.
20 And then the second thing that I
21 would say, and maybe Ernest wants to speak to
22 what he means by community, but I think the

1 second thing is, as we know from all the work
2 done at Dartmouth that continues to be shown
3 over and over again, there are regional
4 differences in healthcare that are just
5 geographic in nature.
6 And again, if we are going to
7 somehow give people, make the level playing
8 equal by saying, okay, you're in this
9 community where healthcare expenditures are
10 twice as much for the same healthcare costs, I
11 know that's not what you're talking about
12 here.
13 But I'm just saying using that as
14 an example then, again, we're just adjusting
15 to allow the status quo to keep going on. I
16 think it's important to know what we're doing
17 for each population but maybe not to give
18 people a pass for, but I already said that.
19 But, Ernest, I'd be interested in
20 what you mean by community and how you would
21 adjust by community. Because I was just
22 saying, I think it's really hard to actually

1 define community and what that means.
2 MEMBER MOY: Yes, I know. I was
3 thinking more from Helen's question, is more
4 work needed. And I think the answer is yes.
5 I thought it would be an
6 interesting experiment because if we are,
7 putting aside community resources, which is
8 really important, but if you wanted to measure
9 community resources you wouldn't look at
10 readmissions. There's a lot of other things
11 you'd look at instead.
12 So if you're looking at
13 readmissions, I think you really want hospital
14 quality of care. And I think that one of the
15 big drivers you want to then take out of that
16 are the community factors, so that you can
17 focus in on the quality of care delivered by
18 the hospital.
19 And I'm thinking that maybe a
20 proxy for those community resources is simply
21 the underlying rate of hospitalizations for
22 community to take out the geographic factor,

1 to take out the fact that in rural communities
2 you're more likely to hospitalize someone so
3 that they don't have to drive 60 miles, things
4 like that. This's more of a research, I
5 think, suggestion.
6 CO-CHAIR ANDRULIS: Kevin and then
7 Ellen.
8 MEMBER FISCELLA: A couple things,
9 I think it's important to keep in mind what
10 our overall goal is and that's to have an
11 impact on healthcare disparities, particularly
12 those that are going to improve and narrow
13 those disparities in health.
14 I agree with the discussion around
15 the difficulty in defining community factors.
16 I do think you could adjust for the
17 composition of who's in the hospital, which
18 would be different than adjusting for the
19 individual patient level factor.
20 So for example, you could adjust
21 for the median income, zip code of the patient
22 who was admitted, or the percent Medicaid, or

1 the percent uninsured. You could even do race
2 and ethnicity.
3 Really all these are various
4 proxies, potentially, for the resources that
5 the hospital has to care for that group in
6 order to level the playing field.
7 But I think that that would make
8 more sense than to get into the whole quagmire
9 of the community itself and how to do that in
10 an equitable way.
11 CO-CHAIR ANDRULIS: Ellen?
12 MEMBER WU: I understand the
13 desired need to focus and what we're looking
14 at and measuring. But I feel like we're
15 losing this larger picture that the hospital
16 is part of a community.
17 And community clinics and all
18 these facilities originally grew out of a need
19 within a community. And they're a part of a
20 community. And I think that part of their
21 responsibility and charge is actually to
22 manage the health, not just care, in

1 healthcare, but the health of their patient.
2 So I don't know how to do it. But
3 to adjust away all of the community factors,
4 and just have the hospital focus within that
5 hospital four walls, I think we're not going
6 to get at the disparities. And we're not
7 going to hold our healthcare system
8 accountable for providing more health and
9 wellness than just sick care.
10 And Jerry joked about we're trying
11 to change the healthcare system, but in all of
12 these little pieces that we do around quality
13 and coverage, the exchange, there are
14 opportunities to start adjusting it, to start
15 transforming it a little bit.
16 There's a window open to really
17 start shifting the way we do things, either
18 through reimbursement or how we measure
19 things, what we look for. So I just think
20 that that's really important.
21 I know it's hard, I know it's
22 complicated. But I'm really concerned that if

1 we keep doing the same old, same old, and
2 being very siloed about it, we're going to
3 lose this opportunity.
4 CO-CHAIR ANDRULIS: Liz.
5 MEMBER JACOBS: This one comment
6 keeps coming back to me. But going back to
7 what Kevin said, I think that, because maybe
8 these hospitals have to do more to take better
9 care of these patients, and so if we should
10 adjust for these things and then that way
11 it'll equalize the playing field.
12 Again, it's not highlighting and
13 addressing the problem, which is that these
14 hospitals need more resources. Is there
15 someway in which this could be used to
16 highlight how these hospitals need more
17 resources, instead of just giving them the
18 same amount of money for the reimbursment, or
19 doing something like Donna was saying, I think
20 is an issue.
21 And I think back to being at Cook
22 County and a colleague of mine said to me, who

1 now actually is in the leadership there, which
2 drive me nuts, said to me not every patient
3 with diabetes can get a retinal exam every two
4 years.
5 We're a county, we can't do that.
6 And I'm like, that is the standard of care,
7 how can you say that. But that's what happens
8 in these places.
9 And I'm afraid that if we say,
10 okay, it's resource poor and so we should not
11 hold them to the same standard because they
12 need more resources to take care of these
13 patients, again, it just promotes this kind of
14 way in which we give second-class care to
15 these patients.
16 DR. BURSTIN: Thank you, that was
17 a great discussion. It's as complex as we
18 thought it was, I think, when Taroon and I
19 walked in.
20 (Laughter)
21 DR. BURSTIN: And I think probably
22 where we've landed to date is probably

1 appropriate, which is comparing like hospitals
2 to like hospitals as being a recommendation
3 for reporting, and not adjusting at the
4 individual patient level, which we agree with.
5 I will point out, interestingly
6 enough, and this isn't really just about the
7 readmission measure although it certainly
8 brought it up for us in a big way recently,
9 there is actually a significant pot of money
10 available through ACA, the Affordable Care
11 Act, for hospitals who perform poorly on the
12 readmission rates.
13 So some of this is also, you don't
14 want to adjust away those differences and have
15 the hospitals that are actually the least
16 resourced to do poorly and not get that pot of
17 money. So these are really complex issues so,
18 thank you.
19 CO-CHAIR ANDRULIS: Okay, Romana.
20 MEMBER HASNAIN-WYNIA: To Liz's
21 point, I was just telling Marshall, there's
22 this very interesting little article, if you

1 haven't seen it, by Jan Blustein, in June 2010
2 of the PLoS publication, the open access,
3 entitled "Hospital Performance, the Local
4 Economy, the Local Workforce, Findings from a
5 U.S. National Longitudinal Study."
6 The only reason I point that out
7 is because one of the things that Jan does in
8 this analysis is she looks at improvement and
9 attainment.
10 And the thing that's very
11 interesting is that the hospitals in the very
12 under-resourced communities, after a
13 pay-per-performance implementation, all
14 improved. They don't all close the gap but
15 their absolute improvement is far greater than
16 any movement that was made by the hospitals.
17 We all know this, those of us who
18 look at pay-per-performance and improvements.
19 And so it comes back to Marshall's point in
20 terms of should we be paying for absolute or
21 for improvement. And I would just encourage
22 whatever NQF puts out to --

1 DR. BURSTIN: We'll definitely
2 pull that. The Values Purchasing program
3 does, in fact, do that. It pays for both the
4 actual attainment of a goal versus the journey
5 getting there so it is interesting. Great,
6 thank you.
7 CO-CHAIR ANDRULIS: Last word,
8 Kevin.
9 MEMBER FISCELLA: At the risk of
10 introducing what may seem like an irrelevant
11 topic, I will say that with No Child Left
12 Behind there's a realization that people
13 needed to move beyond absolute performance,
14 that is every child would be at this adequate
15 reading level.
16 I think it was by 2014 or
17 something like that, otherwise you would risk
18 being closed down and all these punitive
19 sanctions, to really progress towards a goal
20 and in looking at how a cohort of kids are
21 doing and improving and finding ways to
22 incentivize realistically attainable goals.

1 CO-CHAIR ANDRULIS: I think we're
2 on for a break for ten minutes. See you back
3 here in ten minutes.
4 MS. MCELVEEN: Yes, so what we're
5 going to do is we'll take a quick break. We
6 realized we just had breakfast, lunch is out
7 because we originally planned for 11:15 lunch.
8 It's a little early.
9 What we think is the better thing
10 to do is take a break, come back, we'll start
11 on the next piece and then break for lunch in
12 an hour. Is that okay with the group?
13 (Whereupon, the above-entitled
14 matter went off the record at 10:59 a.m. and
15 resumed at 11:14 a.m.)
16 CO-CHAIR ANDRULIS: Okay, we're
17 going to move on to a discussion around the
18 Disparity Sensitive Measures Assessment. And
19 there are a few questions that will be put
20 forth to us for consideration. And for that I
21 hand you over to Nicole.
22 MS. MCELVEEN: Okay, so you all

1 may recall one of the other pieces we're
2 involved in is identifying measures that are
3 NQF endorsed as disparity sensitive. And we
4 have proposed protocol to the group that you
5 have provided a lot of feedback on.
6 And so the first thing I want to
7 do is just quickly recap what that protocol
8 was and then discuss with the group the
9 process that we've continued on and the
10 results of that process in this assessment.
11 So now, if I can direct your
12 attention to the large screen in the center,
13 we'll use this for the slides following. So
14 there were several pieces to this protocol,
15 again, proposed initially through the
16 commission paper to the group.
17 And so what was decided is that it
18 would be separated into two tiers. The first
19 tier is looking at prevalence, quality gap and
20 impact. So specifically within prevalence,
21 we've directed our attention around measures
22 that address the following healthcare

1 conditions that are listed there.
2 So focusing on any measures that
3 address, cancer, diabetes, for example,
4 tobacco use, oral care, substance abuse, as
5 well as cross-cutting areas such as patient
6 safety care coordination, our palliative care
7 and any measures around child heath or
8 pediatrics.
9 Second component is around quality
10 gap. And within our measure evaluation form
11 there's a section that specifically asks for
12 information around disparities as it relates
13 to the quality gap.
14 And we're using that particular
15 section to identify measures and to fill in
16 that indicator. And I'll talk more about that
17 shortly.
18 Third, on the first tier is
19 impact. And we're assessing that by deciding
20 whether a measure can be mapped to any of our
21 national priorities partnership goals or
22 measure concepts that are laid out through

1 that work.
2 The second tier of the protocol
3 focuses on care with a high degree of
4 discretion. And to assess that, we're
5 reviewing the measure submission forms that
6 have indicated or cited a guideline as part of
7 the evidence for that measure.
8 Second is addressing community
9 sensitive services. And we are assessing that
10 indicator based on if a measure can be
11 identified or matched to one of our cultural
12 competency practices addressing communication,
13 or any practice falling under the care
14 coordination project that addresses
15 communication.
16 The third component is social
17 determinant dependant measures. This
18 indicator, the committee had quite a bit of
19 feedback on at our last call.
20 But we're assessing this based on
21 whether the measure is primarily within the
22 direct control sphere of the healthcare

1 delivery or public health system, or whether
2 it addresses a behavioral aspect of healthcare
3 or is primarily an environmental aspect of
4 healthcare.
5 And then finally we're tagging all
6 of the measures based on a specific category
7 that's laid out, so whether the measure is
8 more focused on practitioner performance,
9 whether it's indicated to be hospital or
10 ambulatory care, home health.
11 And then also if it's a system
12 provider based measure, whether it's
13 cross-cutting, whether it's a structure
14 process or outcome, so those indicators are
15 ones that we are identifying for all the
16 measures that are included in the assessment.
17 So to date, let me kind of go
18 through some of the results that we have
19 completed. So to date we've reviewed about
20 250 measures. Out of those measures 114 were
21 included in this assessment.
22 And so in the review process of

1 our portfolio there are many measures that
2 were previously endorsed that are now under
3 review again as part of our maintenance
4 process, as well as annual updates. So if
5 that is the case, we did not include that
6 measure in the current assessment.
7 So looking at prevalence,
8 prevalence was very high, of course because we
9 specifically addressed measures against it
10 within those conditions that I just read. So
11 about 94% or 80% of the measures that were
12 reviewed scored very high for prevalence.
13 Looking at the indicator for care
14 with a high degree of discretion, again, does
15 the measure form cite a clinical guideline?
16 About 60% of the measures were linked to a
17 specific clinical guideline and a citation was
18 provided.
19 Communication sensitive services
20 was a little lower and that wasn't really a
21 surprise to us as we looked through the
22 measures. But there were really only five

1 measures that could be mapped to the practices
2 that we've laid out within cultural competency
3 and care coordination. And those were
4 measures from the Child Health and Palliative
5 Care Project.
6 Social determinate measures,
7 majority of them were identified to be within
8 the direct control of the healthcare delivery
9 of public health System. So that was well
10 over 100 measures that we went through. And
11 then the remaining measures shook out. For
12 process measures there are about 64, outcome,
13 about 50 measures.
14 And then about ten, or a really
15 small percentage, around eight percent of the
16 measures were scored high for all of the
17 indicators of the protocol. So that includes
18 measures that were also linked to the
19 practices as well.
20 The other piece of this process
21 involved, again, identifying the quality gap.
22 And on our last call I communicated to the

1 group that many of the measure forms did not
2 indicate information around disparities. And
3 so the goal to fill in that information was
4 for NQF staff to do a literature search and to
5 do our best to fill that information in.
6 And so the quality gap, in the
7 large Excel spreadsheet that you all received,
8 it includes a numeric value based on specific
9 information that was included in the measure
10 form.
11 So approximately 60 measures, or
12 50 percent of those that we assessed, we were
13 able to retrieve that information, either from
14 the measure form itself or based through
15 literature searches that we did on the staff
16 side.
17 And the distribution was pretty
18 wide. It varied, as you can see on the screen
19 there, from 1.5 percent negative, 1.5 percent
20 to 39 percent. And we'll go through more
21 details of those numbers in a minute.
22 This slide shows that distribution

1 in a little more detail if you can see the
2 numbers. So the range is listed on the top of
3 the graph. And then the number of measures
4 that fell within that particular range is
5 listed on the bottom.
6 So again, most of the measures
7 were less than one percent for a quality gap.
8 And then several others falling between two
9 and three percent and then another third or so
10 fell a little higher between ten and 20
11 percent.
12 So within the large spreadsheet
13 that we provided to you there were also, of
14 course, outliers within that gap information.
15 And we tried to highlight those cells on the
16 spreadsheet. We did highlight them in blue if
17 you're viewing that. And we'll project that
18 in a minute.
19 So more than 70 percent of the
20 measures that we identified had a quality gap
21 of ten percent or less, as I just mentioned.
22 But specifically speaking to the outliers,

1 there were measures that were specified more
2 on a population level. So, of course, when
3 you're thinking about a quality gap for a
4 larger population it was just a larger number,
5 naturally.
6 There were also measures that were
7 not specified in a percentage or numeric
8 value. It was more of a narrative given to
9 address disparities.
10 We also included quality gap
11 information around the general concept of the
12 measure versus the specifics of what the
13 measure was measuring. So those were the
14 three outliers that we wanted to bring to the
15 attention of the workgroup.
16 So finally, the distribution for
17 the scoring, as you know, for each measure
18 that we tagged there was a scoring at the end
19 that was provided. So the scores that are
20 listed do not include quality gap. Because we
21 did not specifically score that indicator
22 because we were still working on it.

1 But just to give you a
2 distribution of the scoring, for the first
3 tier the scoring ranged from about three to
4 five. And then second tier was one to nine.
5 Overall scores were distributed between five
6 and 13. And when we pull up the spreadsheet
7 we'll be able to talk through some of the
8 specifics around that and what that really
9 means.
10 So with this information there's a
11 few things we wanted to bring to the
12 committee's attention and to get your feedback
13 on. The first, and probably most important,
14 is how should that quality gap data be used?
15 So do you first think that you
16 want to really consider the quality gap as a
17 high indicator? Because we're really
18 struggling with identifying that information
19 and filling that in in a complete way.
20 Should that be weighted high in
21 terms of tagging measures as disparity
22 sensitive? Or does the committee want to

1 consider classifying the quality gap as, let's
2 say, 15 percent or higher to really count
3 towards the scoring of each of the measures?
4 And then how should we really
5 address the issue of measures that there just
6 was no data identified? And how will that
7 weigh into the decision around identifying
8 what the quality gap is for that group?
9 And then we do also have some
10 additional questions around how to address the
11 outliers and the scoring for the measures that
12 we've identified, but first, taking it in
13 pieces. I think the first step would be to
14 start to think about that indicator of quality
15 gap.
16 MS. MCELVEEN: We're pulling the
17 spreadsheet up on the screen but you do have a
18 copy of this in the electronic material that
19 was sent out. So if you can't see it you
20 might want to pull that out.
21 MEMBER WASHINGTON: Are you asking
22 for comments now or were you planning to go

1 through the, actually a question and a
2 comment. The question is how did you arrive
3 at the 15 percent. That seems a little bit
4 arbitrary in the sense that smaller gaps in
5 high impact areas might be quite relevant so I
6 would just --
7 DR. BURSTIN: It was totally
8 arbitrary to get you to start talking about
9 it.
10 MEMBER WASHINGTON: Oh, okay,
11 great. And then just to start the discussion
12 on how the gap data should be used, looking at
13 the two tiers it seems that areas where there
14 are either high gaps or some combination of
15 moderate gaps and high impact, you might think
16 about that as inclusion for considering that,
17 or labeling that as a disparity sensitive
18 measure.
19 While others you would then move
20 on to the second tier and look at other
21 factors. So I would not use either absence of
22 data or lack of documentation of a disparity

1 as an exclusion, but rather as a reason to
2 move on and look at other factors.
3 Part of the danger of taking the
4 reported data, having gone through the process
5 yesterday and having a better understanding
6 about where some of the data comes from that's
7 reported in these measures, then unfortunately
8 I wouldn't make too much about the presence or
9 absence of a gap.
10 It could be a very biased sample,
11 it could have been targeted for specific
12 purposes. And so it may not necessarily
13 reflect the broader literature, on the one
14 hand.
15 On the other hand the broader
16 literature, which might document known
17 disparities in an area, would point to the
18 need for a measure. And it just may be a
19 lousy measure for assessing disparities. And
20 so it's useful information but it's not
21 everything.
22 CO-CHAIR ANDRULIS: Nicole, do you

1 want to take us through a --

2 MS. MCELVEEN: So for those of you

3 who are able to pull up the spreadsheet --

4 Sorry, we're just trying to choose

5 the best example. So to highlight one of the

6 outliers for, under quality gap again, we're

7 looking at Line 77 in the spreadsheet and

8 we've also pulled it up on the screen there.

9 This is a measure from our cardiovascular

10 project looking at hospital all-cause, risk-

11 standardized mortality rates.

12 And so the quality gap

13 specifically for this was fairly high compared

14 to many of the other measures within this

15 project. And that was around 16 percent.

16 DR. NISHIMI: So let's walk all

17 the way across on how it was scored. It got

18 three, the highest number of points, under the

19 prevalence. Documentation was provided and

20 the highest disparity was 16.8 percent. So

21 that's the value there.

22 You see a blank slot because that

1 was where the committee was perhaps going to
2 make judgements on. Zero to five is a small
3 gap, five to ten is a medium gap, it might get
4 two points. And ten and above are our example
5 we just threw up for your consideration.
6 Fifteen and above gets three points, again,
7 remembering that there's a "total score"
8 that's going to be at the end.
9 And if you keep going across you
10 see it was assigned impact, a one, it didn't
11 cite a specific guideline so it got "zero"
12 points. This was matching to the cultural
13 competency practices, is that right?
14 Care coordination practices,
15 things got certain points, the social
16 determinant issue, that was a staff level
17 judgement, is that right? Staff had to make
18 the assessment there.
19 The next few aren't point values,
20 they're just descriptive. So that at the end
21 when you looked at the entire "disparity
22 sensitive" set you could say, oh my gosh, we

1 have absolutely no process measures, or
2 something like that. So that's a descriptive
3 field, whether it was a consumer survey,
4 provider base, et cetera. So those are all
5 descriptive type things.
6 And then what was done was, if you
7 recall what you discussed, that there was
8 going to be a "first tier score and a second
9 tier score." And so based on that cells were
10 added up. And then there are various comments
11 that we had to make to keep track of what was
12 going on.
13 So that's what was done for each
14 of the measures. And really, the question for
15 you right now that I think Nicole wants to
16 focus on, is this notion that we'll phrase the
17 fact that, do you want that quality gap score
18 to still be a first tier issue.
19 Frankly, given that we don't have
20 data for 50 percent of them, you all might be
21 able to point to a few more articles, et
22 cetera, where we might have gap information.

1 But the sheer fact of the matter
2 is, there are going to be a lot of measures in
3 the NQF portfolio that don't have gap
4 information.
5 And so then you have to start
6 making qualitative assessments, you meaning
7 you, not meaning us as staff, about how to
8 weight these things to put them in or out for
9 them to have the set narrowed somewhat for you
10 to make some final recommendations.
11 And these are only what, half the
12 measures, third the measures, that have been
13 added. So we're trying to winnow the list
14 down so that you can make more informed
15 decisions. But we need to do so in a logical
16 protocol-specific way so that what comes out
17 at the end doesn't look to the outside like it
18 was just this ad hoc, gut level thing.
19 MS. MCELVEEN: Kevin?
20 CO-CHAIR ANDRULIS: Kevin, you
21 wanted to talk?
22 MEMBER FISCELLA: Yes, I think I

1 would advocate for considering the size of the
2 quality gap. I look at this as very much a
3 work in process. And we're just getting
4 started here. And I think it makes sense, for
5 a number of reasons, to start where we know
6 disparities are and where we at least know
7 them to be the largest.
8 That doesn't mean that there
9 certainly aren't unknown areas that are much
10 larger. And those will be identified through
11 future research and then can be targeted.
12 I think one rationale for starting
13 with where they're largest is simply the
14 population impact. You're going to have the
15 biggest, assuming you're taking into account
16 prevalence as well, but if there's a bigger
17 quality gap and you close that gap you're
18 going to have the bigger impact.
19 Secondly, there's all sorts of
20 statistical issues that come with looking at
21 very, very small gaps. And whether one is
22 really making a difference there, that becomes

1 more challenging.
2 And I think it's important to have
3 some early successes and I think if you have a
4 bigger gap that you're going after there's a
5 bigger opportunity to show improvement.
6 CO-CHAIR ANDRULIS: Colette?
7 MEMBER EDWARDS: I have two
8 questions and one is just so I understand the
9 scoring a little bit better. Where it has
10 care coordination practice, and I can't
11 remember exactly how that was defined as not
12 applicable, if I'm reading correctly. How was
13 it determined to not be applicable related to
14 death within 30 days and the whole admission.
15 DR. NISHIMI: Because it actually
16 doesn't map to a specific practice. You'd
17 have to have the report in front of you,
18 unfortunately. Obviously it's a care
19 coordination issue --
20 MEMBER EDWARDS: Right, that's
21 what's confusing me.
22 DR. NISHIMI: -- which is a

1 discussion that we could have. But the way
2 the field was initially described, that the
3 committee viewed, was does it really map to
4 one of the NQF endorsed practices, the actual
5 practice, not whether it's a care coordination
6 issue.
7 MEMBER EDWARDS: And then my next
8 question has to do with what we were being
9 asked to do in terms of where it says, no gap
10 for identified and make a consensus decision.
11 Are you saying that we would do it measure by
12 measure or we would say, for all measures that
13 don't have gap data we're going to say they're
14 disparity sensitive? Is that what our options
15 are?
16 DR. NISHIMI: I think the decision
17 is at some level you all have to decide what
18 we do about those, measure by measure --
19 MEMBER EDWARDS: So it's open
20 right now, is what you're saying?
21 DR. NISHIMI: Yes.
22 MEMBER EDWARDS: I didn't know if

1 there was something implied by the way the
2 question was raised?
3 DR. NISHIMI: No.
4 CO-CHAIR ANDRULIS: Liz, then
5 Ernie and Ellen.
6 MEMBER JACOBS: I think the idea of
7 going where we know there's a gap is a great
8 one, like Kevin was saying, to help narrow it
9 down. But I'm wondering if we also want to
10 see, if we do that, are there important areas
11 in which we want to do measurement that are
12 left out, like is it all in cardiovascular
13 disease or all child's health, or something
14 like that.
15 And so maybe we want to do that
16 and then say, okay, are there important areas
17 that we're missing doing the measurement, and
18 then add a few in that we don't know there are
19 gaps but are likely to be gaps, to cover the
20 breadth of things we might want to measure
21 disparities or cultural issues.
22 CO-CHAIR ANDRULIS: Ernie?

1 MEMBER MOY: I think basically the
2 same comment, but specifically I'm thinking
3 how people might use NQF lists. And I'm kind
4 of thinking that they might be a hospital and
5 they're looking at hospital measures, or a
6 nursing home looking at nursing home measures.
7 You might take the measure within a provider
8 type that has the largest gap and say that's
9 more disparity sensitive than the others.
10 CO-CHAIR ANDRULIS: Ellen?
11 MEMBER WU: I think I'm just
12 looking at this a little bit more
13 pragmatically. Do you have it listed by gap
14 measure? Can we --
15 DR. NISHIMI: By the quality gap
16 field?
17 MEMBER WU: Yes.
18 DR. NISHIMI: Yes, she can do that
19 right now, largest to small.
20 MEMBER WU: Yes, so then do we see
21 a natural cut-off?
22 DR. NISHIMI: The point was you

1 don't really have, that's why we gave you that
2 table of distribution.
3 That's the distribution now.
4 CO-CHAIR ANDRULIS: Donna, then,
5 Kevin, you still -
6 MS. MCELVEEN: We're going to try
7 and make it a little larger.
8 MEMBER WASHINGTON: We have to be
9 a little cautious about interpreting some of
10 the numbers. I just arbitrarily pulled up one
11 of the cells to look at the details behind the
12 gap. I looked at Number 1454, the proportion
13 of patients with hypercalcemia. And the gap
14 listed --
15 MS. MCELVEEN: I'm sorry, what
16 line on the Excel spreadsheet is that?
17 MEMBER WASHINGTON: You know what,
18 I sorted mine so I'm not sure. Look under
19 Column A, it's measure 1454. Oh, there it is.
20 It's right there, the one that's right on
21 top. It lists a quality gap of 39 percent.
22 But if you scroll over to the

1 column with the explanation then actually it
2 reports out the percentages by race/ethnicity.
3 So for whites it's 39 percent, African
4 Americans it's 41 percent, Hispanics, nine
5 percent, and Asians, two percent.
6 So that gap of 39 percent is
7 actually looking at African Americans minus
8 Asians. And I think there was guidance about
9 how to calculate the gap looking at the
10 historically advantaged group as the reference
11 point. So in essence this 39 percent gap is
12 actually a two percent gap.
13 DR. NISHIMI: Well actually
14 though, the agreement when we went through the
15 protocol was to choose the largest gap
16 between, when we first reviewed this, so not
17 just between the historically disadvantaged
18 and not.
19 It was of the race and ethnicity
20 data that we found what was the largest gap
21 between the populations that were reported.
22 We could change our minds now but I just want

1 to point out that that was the decision that
2 was made and sent.
3 MEMBER WASHINGTON: Okay, but it
4 still just reflects that whatever arbitrary
5 cut point we come up with we also need to look
6 within the data to understand what that cut
7 point reflects, or what the data reflects.
8 DR. NISHIMI: Yes, but to me two
9 percent of the people of my ethnic background,
10 racial background, however you want to
11 characterize it, are getting damn good care
12 and other people are not. So I do think you
13 want to use the largest gap, that's just me
14 personally.
15 C0-CHAIR ANDRULIS: Kevin?
16 MEMBER FISCELLA: This is just a
17 clarification question. The gap, does it
18 reflect the absolute difference in rates
19 between the highest and lowest? And these are
20 always true rates that we're looking at the
21 difference between?
22 DR. NISHIMI: For almost in all

1 cases, yes, but that's what some of the
2 outliers were that Nicole pointed out. There
3 was one that was based on there's a gap of
4 point five nanograms per deciliter between two
5 different populations. We reported that but
6 you can't translate that to a rate. But when
7 you see these percentage, those are rates.
8 MEMBER MOY: Yes, just on that so
9 you might want to have special consideration
10 for things that aren't percentages, so
11 differences in mortality rates, which would be
12 really low, which might still be important.
13 CO-CHAIR ANDRULIS: Marshall?
14 MEMBER CHIN: I guess another
15 factor that maybe some of the different
16 columns partially get at, but still maybe not
17 immediately through the most logical end
18 results, really have to do with the
19 distribution.
20 The end results, like Liz was
21 saying, you measure a scenario where at the
22 extreme we have 50 percent of the measures are

1 cardiovascular or adult measures. I know that
2 AHRQ has grappled with this somewhat in terms
3 the same issue, in terms of you have different
4 grids in terms of different factors, whether
5 it's child, adult or preventive care, acute
6 care, surgical, medical, et cetera.
7 But at some point there probably
8 should be a check in terms of does it pass the
9 SNF test of balance, some degree of balance.
10 For example, I can imagine, say for example
11 that there aren't a lot of child measures. And
12 so child measures may not score as highly on
13 these different columns.
14 But wouldn't want to have emphasis
15 which we have no child measures. So some how
16 that probably needs to be built in the system,
17 some type of look at, are we missing major
18 areas where -
19 DR. NISHIMI: Can we have some
20 discussion around, because what we'd like to
21 do is continue the screening and then bring
22 back, to the committee, some of these cross-

1 cuts, if you will. So we would bring back any
2 measure that was 15 percent or higher,
3 whatever you land on. And you could take a
4 look at that.
5 We would then do a sort of
6 measures by area so that you could see that.
7 And this could be all of them or it could only
8 be those that are, let's say, five percent
9 above.
10 A broader swath but of those that
11 are five percent and above you've got 40 of
12 them are cardiac, one child, one pulmonary and
13 one ERSD or something. So then you could look
14 at it that way.
15 We could do some of the other
16 cross-cuts that you've talked about, but
17 absent that kind of guidance, it does devolve
18 to you literally having to go through line by
19 line, which is what is Colette asked. We're
20 talking about line by line because 50 percent
21 of the measures don't have any gap
22 information.

1 So the staff needs some specific
2 guidance on, Number 1, even for those that we
3 have gap information, how do we sort those and
4 bring that back to you. But also, what are we
5 going to do about these measures for which
6 there's just no gap information?
7 CO-CHAIR ANDRULIS: Yes, Mara and
8 then Ernie.
9 MEMBER YOUDELMAN: I missed the
10 December call and I am just drawing a blank on
11 this. But can you just go back to when
12 something is determined disparity sensitive,
13 what happens? Because as you said earlier,
14 that going forward any new measure or reviewed
15 measure is going to have to give this data.
16 This is the interim process until everything
17 is newer reviewed? I just want to confirm
18 that, correct?
19 DR. BURSTIN: At this point now
20 every time a measure comes up for maintenance
21 we request that they submit the data
22 stratified to look for disparities. So we'll

1 gather actual gap data on the use of the
2 measure in performance.
3 DR. NISHIMI: But that doesn't
4 mean it's necessarily disparity sensitive.
5 You all are here to kick things up to that
6 level or not.
7 MEMBER YOUDELMAN: So there's two
8 different tracks then. There will be
9 disparity sensitive measures, which must have
10 this data. And there'll be reviewed measures,
11 which, okay, maybe I'm just confused.
12 So reviewed measures will have to
13 give disparities data but may not be disparity
14 sensitive, which means what, if they're not
15 disparity sensitive? Maybe I'm just
16 completely confused.
17 DR. NISHIMI: So if there's no
18 difference in disparities when it comes in
19 through maintenance, then let's say it's a
20 hospital measure. Then a hospital may or may
21 not choose to take a very close look at it,
22 which is not to say that there isn't

1 disparities within each hospital's own
2 populations. But it creates a set where
3 there's clear indication that this is a
4 disparity sensitive measure.
5 DR. BURSTIN: And therefore it
6 should be stratified.
7 CO-CHAIR ANDRULIS: Yes, it sounds
8 like there are almost three groups you're
9 talking about here. There's the group where
10 there's data to show disparity, some
11 differentiation that we want to look at.
12 Then there's the group that you
13 have data that show no disparities. But we
14 want to review that too, to look at the
15 quality and the nature of those measures. So
16 it also gives us a context to see which ones
17 are showing up with no disparities.
18 And then the third group is where
19 there isn't any information on disparities.
20 So there may be all sorts of ways in which
21 we'll cluster this.
22 But I think the idea of having us

1 have an opportunity to look at the way the
2 measures that are currently available, along
3 those three areas, can give us a sense of
4 what's been documented, what has been
5 documented but we want to review to see about
6 whether the data stands, and then about those
7 that there are no data, at least that have
8 been found to date. Ernie?
9 MEMBER MOY: Yes, I guess I just
10 hesitate to flag something as disparity
11 sensitive in the absence of data. Maybe you
12 could just call this pending or no
13 information. And that way that would have
14 people focus on those things that we have seen
15 a demonstrated difference.
16 DR. BURSTIN: And just to add to
17 that, I think that's absolutely right. And I
18 think I do see it as two complementary
19 processes.
20 So the idea here is to say, of the
21 measures we have already got that are in hand,
22 which of those are in areas where we know

1 there are disparities. They fit these
2 criteria, they should be labeled as such. And
3 we encourage people to stratify.
4 Then there's going to be the set
5 of measures prospectively coming to NQF where
6 we're going to be asking them to be submitting
7 their data on disparities and adding to that
8 quality gap piece, which we oftentimes don't
9 have.
10 And we'd like to eventually, and
11 with your help, think through how we get all
12 steering committees to look at those data and
13 make that determination, prospectively, as the
14 measure comes in.
15 They say either this is
16 retrospectively been assigned as a disparity
17 sensitive measure, wow, look, here's
18 stratified data on performance in the last
19 three years.
20 So I think we need to think about
21 but the retrospective piece of this and the
22 prospective piece of this, which I hope will

1 be complementary.
2 DR. NISHIMI: Right, but what I
3 heard, and would be useful to hear, is that
4 when there's no disparities information, that
5 I heard what Ernie just pointed out. He would
6 hesitate making any judgement on it.
7 I also heard comments that they'd
8 like to look at the full range and maybe pull
9 some in there, even if it had no data. So I
10 do think those are two competing ideas.
11 CO-CHAIR ANDRULIS: Yes, Donna,
12 Marshall.
13 MEMBER WASHINGTON: So I've a
14 question and then a proposal for moving
15 forward. The question is, among the measures
16 with quality data then what percent,
17 approximately, were included in the measure
18 versus gathered from the literature search?
19 And then as you're looking that
20 up, the importance of the distinction, picking
21 up on what I said earlier, is that even if a
22 disparity exists the measure may not

1 necessarily be sensitive in detecting it.
2 And so I would more heavily weigh
3 the measures that actually included the
4 stratified data, or data on disparities in
5 some form, in their submission.
6 So if you were looking to willow
7 the list why not choose measures that have
8 already achieved the standard that we're then
9 suggesting for new measures going forward?
10 DR. NISHIMI: I can't give you a
11 number. I do know there was either one or
12 two, since I did some of the literature ones
13 where they had actually used the measure and,
14 for whatever reason, it was an older measure.
15 It wasn't in the form when we required it.
16 So we were able to actually to get
17 specific disparities information from the
18 literature and plug it in because it was the
19 actual measure, in essence.
20 But in terms of what forms, if we
21 just do it by forms, half of the measures
22 right now have disparities information. And I

1 think ESRD and cardiac maintenance was where
2 we really started requiring it. So it's only
3 going to be those two projects right now.
4 Some of the others filled it in,
5 kind of namby-pamby, so catch-as-catch-can,
6 they provided it because before it used to be
7 a field but not an emphasized field. So there
8 might be a few more. But systematically it's
9 those departments.
10 DR. BURSTIN: It's also very
11 dependent on the developer as well. So if you
12 think about it CMS usually doesn't have
13 difficulty with submittals. It was
14 interesting, they discussed it first but
15 managed to find all the data. And in fact
16 submitted it all in cardiovascular, mainly
17 because our chair sent every form back until
18 they submitted it, which was great.
19 But some of other developers may
20 not actually have the data in their hands.
21 They've developed the measure but they don't
22 actually have the data. And so those folks,

1 it will be harder, even prospectively, having
2 them give us that data back.
3 CO-CHAIR ANDRULIS: Kevin, Ernie,
4 Dawn?
5 MEMBER FITZGERALD: Is there any
6 relationship between what's the current score
7 now and whether or not there's data associated
8 with the quality gap? I guess I'm curious. Is
9 everything that's scoring really high, are
10 they the ones also that we don't have data
11 for, which would have me concerned about
12 saying you can't toss it out or is there any
13 relationship at all?
14 DR. NISHIMI: No, she's wondering
15 if the null fields have any relationship?
16 MEMBER FITZGERALD: Yes, in other
17 words, I'm looking at the range of score, the
18 total score.
19 DR. NISHIMI: Right, I understand
20 what you're saying.
21 MEMBER FITZGERALD: If it's ten,
22 11, 12, which appears to be quite high, but

1 yet those are all the ones we don't have
2 quality gap then we've got a dissonance
3 between what we think is a valid quality
4 measure for which we don't have any data.
5 CO-CHAIR ANDRULIS: Any other
6 comments?
7 MEMBER FITZGERALD: And if that
8 were the case then I might argue for a
9 position that says something to the effect of
10 if all other relevant factors of what we think
11 are disparities, related or high, and yet
12 there isn't a quality gap present, then that
13 might be treated differently for all other
14 factors being scored quite low and not having
15 a quality gap.
16 DR. NISHIMI: It's a mixed bag.
17 Right now, the highest total score was 15 --
18 13 sorry, I need new glasses, clearly. And
19 then if you scroll over to the left for that
20 cell there was no data.
21 But in the next one, just keep in
22 mind that that right hand side is the highest

1 going down. So now look at the quality gap
2 data and begin to scroll down. That's fine,
3 she's still in there. No, scroll down, line
4 by line.
5 Like I say, it's a mixed bag.
6 Sometimes there's an actual zero reported gap
7 on the form. A lot of nulls and some that
8 have values.
9 MEMBER FITZGERALD: But is there
10 not the capacity maybe to, and again, I'm not
11 hopefully quantifying how much love there is
12 in the universe.
13 (Laughter)
14 MEMBER FITZGERALD: But you have
15 to take the factor of how many people divided
16 by -- but seriously is there some way to put
17 those two together? And saying that if all
18 other factors of what we conceptually think of
19 as quality are in that concept of value of ten
20 or higher, then the lack of a quality gap
21 wouldn't necessarily toss it out.
22 But the recommendation would be

1 that you need to present that and this update
2 versus those that we scored low on all of
3 those other factors and no quality gap, we'd
4 say, forget it.
5 DR. NISHIMI: That's an excellent
6 cross-cut. Any other thoughts on this
7 torturous spreadsheet? And hat's off, really,
8 to Adella, I'm talking about this and Nicole
9 has been -- Adella has been --
10 CO-CHAIR ANDRULIS: Sean?
11 MEMBER O'BRIEN: I don't have an
12 answer to what to do with the measures
13 evidence, except to say that when I glanced at
14 the report from Dr. Weissman and others I
15 think he wasn't suggesting that you had to had
16 that evidence.
17 He was saying that if you have
18 evidence of disparity that meets the threshold
19 at that point you can rest easy and say that's
20 disparity sensitive. And if not then you
21 still figure out what to do.
22 I was going to say, for looking at

1 the disparities that are tabulated in the
2 spreadsheet, I think it's important to know
3 that these are absolute differences, I
4 believe. And if you have a measure where it's
5 an adverse event it's rare, then probably a
6 ratio may be more useful.
7 CO-CHAIR ANDRULIS: Anything else
8 on this question? You want to move on to the
9 next?
10 MEMBER JACOBS: So my question is
11 should we decide? And it might be helpful,
12 since we're all in the room together, to make
13 the decision now. I hear rousing endorsement
14 for that.
15 That usually happens with people
16 just sitting around.
17 MS. MCELVEEN: So how about this?
18 Why don't we let you get some food. We'll
19 take maybe a 30 minute break or an hour?
20 DR. NISHIMI: Twenty.
21 MS. MCELVEEN: Twenty, okay, I
22 tried.

1 DR. NISHIMI: It's Friday, we want
2 to get you out of here.
3 MS. MCELVEEN: So, again, just a
4 quick break to get some food and come back.
5 And we will continue the discussion.
6 (Whereupon, the above-mentioned
7 matter went off the record at 12:04 p.m. and
8 resumed at 12:49 p.m.)
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1 A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

2 (12:49 p.m.)

3 DR. NISHMI: Okay, so what Donna
4 so nicely did for the group was to look at the
5 issue of total score versus the percent gap.
6 Donna, can you just take it from here and tee
7 up what's going on.

8 MEMBER WASHINGTON: Oh, sure,
9 someone raised the question, and I was curious
10 as well, as to whether there was a correlation
11 between the total score, so the score without
12 the quality gap, versus the quality gap.

13 And what I did was to plot, there
14 were three measures that used units other than
15 percent quality so those aren't reflected
16 here. And there were three with negative
17 scores that I dropped, just to make it look
18 pretty.

19 And so this just plots the total
20 score versus the quality gap. The total score
21 is on the Y axis. You can see there a bunch
22 of clusters around five and around nine, which

1 looks like that's where most of the measures
2 scored there, but a scattering of other
3 scores.
4 And then the gap, which clusters
5 around zero for most of the studies, and that
6 correlates with the distribution of the
7 quality gap but is pretty much stretched out.
8 And just eyeballing it, it looks like there's
9 very little correlation.
10 For example, if you ignore the
11 three dots in the far right then there's no
12 correlation between score and quality. But
13 thinking about how we might use this data, we
14 might want to consider looking at higher
15 scoring and looking at higher quality gap
16 studies to begin with, for example, just
17 arbitrarily drawing cross hairs somewhere and
18 taking the dots in the upper right corner.
19 DR. NISHIMI: Any questions or
20 comments? The only comment is, wow, you did
21 that over lunch.
22 (Laughter)

1 DR. NISHIMI: She actually did it
2 in much less time then lunch. Liz?
3 MEMBER JACOBS: So when I saw
4 this, Donna showed it to me, and I was
5 wondering if maybe, instead of thinking about
6 whether there's a gap or not and having a
7 cut-off on quality gap, what we want to do is
8 maybe look at the scores, the high potential
9 scores, and cut it off that way instead of low
10 scores. It's just a different way of thinking
11 about narrowing the field down.
12 MEMBER WASHINGTON: So high gap
13 plus high score, using whatever cut point we
14 decide.
15 DR. NISHIBI: And therein is the
16 question, thank you, whatever we decide. So
17 if we can have some discussion on that.
18 MEMBER EDWARDS: But can I just
19 ask a clarifying question? Are we saying that
20 would be our starting point or that we're we
21 actually going to discard some things using
22 that methodology?

1 DR. NISHIBI: That would be your
2 starting point to look at. But what we would
3 bring back to you then would not be things
4 initially that fell below the line. Or we
5 could bring you back the spreadsheet with all
6 200 measures at that point, but sorted at the
7 top would be the 30 that were above whatever
8 line you decide.
9 We're happy to bring you back the
10 full thing but we don't think that's a
11 productive use of your time. That's why we're
12 pressing you to draw a line to sort up.
13 Because then the thought would be that we
14 would have work groups depending on the
15 cross-cut.
16 So five of you might look at those
17 measures that sort above a line of eight.
18 Another five of you might look at how the
19 measures sort out when you choose a quality
20 gap of five percent, ten percent, 15 percent,
21 whatever you land on, et cetera.
22 MEMBER EDWARDS: But I guess the

1 question is, is the goal to eventually get
2 through all of them or potentially not do all
3 of them? Because my only concern, as painful
4 as it might be, with not doing all of them,
5 particularly if there's no data, is that if we
6 don't look at it then there's not necessarily
7 ever going to be any data. And there could be
8 an issue.
9 DR. NISHIBI: We could create a
10 work group that's assigned to look at all
11 those measures for which there is no gap
12 information, certainly.
13 MS. MCELVEEN: So the questions
14 that we present to the group now is, should
15 there be a threshold for quality gap, maybe a
16 suggested scoring approach as you were just
17 mentioning. So something, for example, less
18 than or equal to, or greater than or equal to
19 five, or greater than or equal to ten, just as
20 an example.
21 And how should we handle measures
22 with high scores but no information on quality

1 gap? So would these be considered as
2 potential disparity sensitive measures versus
3 definitely calling them disparity sensitive?
4 MEMBER EDWARDS: So then the two
5 options for that second category would be
6 either potentially sensitive versus definitely
7 sensitive, but not not sensitive? Because I
8 was thinking that, okay.
9 DR. NISHIBI: Mara?
10 MEMBER YOUDELMAN: I think I agree
11 with Colette that, on the second question,
12 there is some group that looks at this, makes
13 an analysis one by one as opposed to just
14 saying we're not going to look at these.
15 In terms of the first question,
16 because I'm still struggling with this, we
17 were talking about it a little bit at lunch,
18 that by saying something is disparity
19 sensitive we recognize that there is a
20 disparity in some of the research available.
21 But when you get to an individual
22 hospital or provider, it may have a disparity

1 on that level that is disparity sensitive, it
2 may not. And it may have a disparity on a
3 non-disparity sensitive measure. It can go
4 either way.
5 So I guess for me, I'd rather have
6 more designated as disparity sensitive than
7 not because we know that there are significant
8 disparities. And by having more, we're
9 putting more emphasis on it. And therefore,
10 hopefully, if someone is looking and using the
11 indication of disparity sensitive measure as
12 their determination whether to look at this or
13 not, there are more things that they can look
14 at.
15 So I'd rather be over-inclusive
16 than under-inclusive to give more
17 opportunities for folks to think about this
18 and hopefully do something with it in the
19 field.
20 DR. NISHIMI: Does anyone have any
21 objections to that? But do you have a cut-off
22 point or do you want anything that has

1 disparities data?

2 MEMBER YOUDELMAN: This is where
3 you get beyond my knowledge of the research
4 and it's just not my area of expertise. So
5 what is statistically significant, I can't
6 even say the words, I don't know.

7 So I guess is five lower and
8 therefore more measures are included? So I'd
9 probably say at least five, not 15, not ten.
10 But I don't know if it should go below five to
11 three. That's where I'm not sure I'm
12 qualified to figure that one out.

13 DR. NISHIMI: Well, at that level
14 it's not a matter of statistically different.
15 It's how inclusive you want to be or not. So
16 if you look at the distribution of the quality
17 gap that we have right now, if you cut it off
18 at less than one you're going to drop 22
19 measures. If you cut it off at five percent
20 it's 20 more measures.

21 MEMBER YOUDELMAN: Then this gets
22 back to the discussion earlier of, if we're

1 too inclusive and there's not a significant
2 gap, have we pushed too far. And people are
3 going to push back.
4 So that's why I'm having a hard
5 time. I certainly think five. I would
6 probably argue for lower than that but would
7 want to get other folks' input on what they
8 think is appropriate in figuring this out.
9 DR. NISHIMI: Kevin, I'm going to
10 put you on the spot because you were on the
11 ambulatory sensitive measures when we did that
12 project. So you've been with it from the
13 beginning.
14 Do you have any thoughts about,
15 because we didn't do this kind of ranking
16 there. It was more, you looked at it. Do you
17 have any thoughts on where we might draw the
18 line?
19 MEMBER FISCELLA: Yes, I don't know
20 that there's a clear answer. I think there's
21 two competing issues here, at least that I
22 see. One is the issue of focus and saying,

1 we're going to focus, perhaps as a country, on
2 these as high priority areas and really try to
3 hit them and do them well, versus the
4 competing need for inclusiveness and lots and
5 lots of measures with the potential for less
6 focus and less movement.
7 So I don't think that there's a
8 magic answer here. But I think it is
9 important for the group to think about how
10 many measures we want to have at the end of
11 the day and to be thinking about those two
12 competing issues, the issues of inclusiveness
13 and representativeness versus the opportunity
14 to focus and perhaps make a greater impact on
15 fewer.
16 DR. NISHIMI: I'm sorry, Marshall,
17 then Ellen, then Ernie.
18 MEMBER CHIN: It's a question
19 maybe for Ernie and others who may know. So
20 I'm assuming that these quality gaps, I don't
21 know if it's correct, are these national
22 numbers? It really depends upon the measure

1 in terms of where the literature is coming
2 from.
3 In other words, the question for
4 Ernie really is well, what do we know in terms
5 of regional variation, such that even if a
6 measure maybe, aggregate from these studies,
7 have zero disparity.
8 If there's significant regional
9 variation then it may be something that we
10 might still consider in terms of giving
11 regions or organizations the flexibility to
12 pick things that are relevant for them.
13 MEMBER MOY: Yes, you can pick
14 anything and there'll be so much regional
15 variation that you're going to find disparity.
16 So that's just the way it is.
17 DR. BURSTIN: And just to
18 follow-up on that most of our measures are
19 used at a national level. So I think we're
20 trying to keep it applicable at this level.
21 But I also think communities could use these
22 criteria to help understand, within their

1 community, which measures they would always
2 want to stratify on.
3 So I guess the question is it also
4 just a useful sorting tool for a community to
5 help think through where they may have issues
6 and they should always stratify.
7 DR. NISHIMI: Ernie, you had your
8 email, and I'm sorry.
9 MEMBER MOY: Yes, instead of this
10 being a flagging thing, disparity sensitive or
11 not, can it be a label that quantifies the
12 amount of disparity, that it's been observed
13 in the world?
14 So there might be a category for
15 large disparities demonstrated for something
16 that's more in ten percent, and moderate for
17 five to ten percent, and small disparity for
18 zero to five percent. Does it have to be a
19 yes, no kind of variable or can it be
20 something that is more descriptive in nature?
21 DR. NISHIMI: I don't see why not,
22 do you?

1 DR. BURSTIN: Marshall, do you
2 want to speak to what went on at the MAP
3 because I think that has some direct relevance
4 in terms of selection of measures? Do you
5 want me to do that, you keep looking confused.
6 MEMBER CHIN: I'm not sure if I
7 know what you're talking about, Helen.
8 DR. BURSTIN: Marshall, I thought
9 it was your suggestion. In a parallel part, I
10 think you asked the part about the measures
11 application partnership. They're helping with
12 the selection of measures for pre-rule making
13 on the part of CMS.
14 So one of the criteria we actually
15 put into place for how they would look at an
16 overall set of measures for a given program,
17 like the in-patient quality rule, or the
18 out-patient rule, or the nursing home rule, or
19 the home health rule, is one of the criteria.
20 We said, are there just disparity
21 sensitive measures building prospectively what
22 we hope this will provide. So the idea would

1 also be that that flag is important.
2 Although underneath it you should
3 be able to see the data. Because I think we'd
4 like to make sure that in all of these
5 programs they are, in fact, pulling in some
6 measures where there are disparities and they
7 should be looking at, and asking hospitals and
8 others to stratify.
9 So it actually has a direct
10 applicability to the selection of measures.
11 So I thought that was your suggestion
12 Marshall, sir.
13 DR. NISHIMI: Ellen?
14 MEMBER WU: I guess my question is,
15 in your previous experience about putting out
16 measures, has there been a number of measures
17 that seems doable, not overwhelming but enough
18 that it's comprehensive, a range?
19 DR. BURSTIN: In the ambulatory
20 care project we selected what, about 35, I
21 think, Kevin, ambulatory care sensitive
22 measures out of a couple of hundred, is that

1 about right?

2 So I don't know that we know what

3 the right number is. But I think, as you've

4 all pointed out, it's a balancing act between

5 wanting to keep focus on what's most important

6 and yet not wanting things, where there's

7 potential disparities, to not get looked at so

8 that you could find where there are

9 disparities. So I think it's really a

10 judgement call on your part.

11 DR. NISHIMI: Jerry and then --

12 MEMBER JOHNSON: Yes, in the

13 interest of us making a decision at some

14 point, let me make a concrete suggestion that

15 just builds on what others have said.

16 First of all it sounds as if we've

17 said that maybe eventually we were going to

18 try to do almost all of these anyway. So the

19 real question is how we prioritize what we do

20 first. It seems like that's what we're

21 deciding.

22 And so suppose we say that we

1 would start with those with a quality gap over
2 five and that would give us about 28. And
3 then if we go back to that chart that Donna
4 had before and look at just the total score
5 and take total scores above some number,
6 actually say ten or more, then that would pick
7 up some additional ones.
8 And then what I would do is look
9 at that group and see, in the categories here,
10 whether we actually at least have a measure
11 under each type of condition.
12 So even though there are 20
13 measures or 20 conditions, there are not 20
14 different types of conditions. There are four
15 or five here that are cardiovascular and a few
16 that are cancer and a couple that are
17 behavioral health, and so forth.
18 So I think we would want to have
19 at least one measure in each of the different
20 types of conditions. So I would just do it in
21 that stage.
22 First, quality gap cut off, then

1 total score, and then get some measure from
2 every condition and say this is the first set
3 that we'll look at.
4 We'll look at this set first,
5 maybe now we have 35, 40 measures. I don't
6 know what it would be. And let's do those
7 first and then move on.
8 DR. NISHIMI: I think that's good.
9 Are people comfortable with that? And then
10 what we could also do along that line, Jerry,
11 thank you for that suggestion, is in addition
12 to the conditions look at the settings.
13 So that if they all end up being
14 hospital measures then we'll pull up nursing
15 home, the SNF measures, we'll pull up the top
16 two, home health, and do it that way. Okay, I
17 think that's good guidance for the taggers, as
18 we call them.
19 DR. BURSTIN: It also has to be
20 interesting as we're going through the next
21 set of projects. We're doing pulmonary right
22 now where just the committee meeting's coming

1 up next month.
2 It might be interesting to
3 actually pull some of those data from those
4 just to give you that flavor of a prospective
5 set, of how you might do this going forward
6 with the data that comes in.
7 DR. NISHIMI: And so with that in
8 mind I would like you to at least take away
9 the second question, how are we going to
10 handle measures with high scores or medium
11 scores, whatever. But we have no information
12 and we heard conflicting views on that.
13 Not something that we have to
14 decide today, but I do think that the
15 committee's going to have to land on a
16 justification of anything that it might move
17 into potentially disparity sensitive. Or I
18 would argue you couldn't classify it disparity
19 sensitive, personally. But some of you might
20 want to.
21 So you're going to have to do some
22 thinking around that. And it would be useful

1 if you could start thinking about it now while
2 the issue's fresh in your mind and email
3 Nicole your thoughts on how we're going to
4 handle that.
5 Even if you call them potentially
6 disparity sensitive, or high, medium and low,
7 which I liked Ernie's suggestion, you're going
8 to have to justify how you got to those
9 places. Helen, you have any, oh, Kevin, I'm
10 sorry.
11 MEMBER FISCELLA: I was going to
12 say, related to that issue is what are next
13 steps after the committee? Because I think it
14 would be easier for me if I knew what the plan
15 was in terms of data collection for all of
16 these areas where we don't have any data.
17 And we have no idea, or don't have
18 a good idea, of whether there are disparities
19 there and who might be affected and how big
20 they are.
21 DR. BURSTIN: It's a great
22 question and thinking more about the

1 prospective arm of this, we talked a little
2 bit this at one of the in-person meetings
3 about our submission form.
4 But we will be re-doing our
5 submission form this summer with a pretty
6 large scale overhaul. We're actually going to
7 be moving, we think, to splitting out the
8 endorsement process into two stages.
9 So that the first stage will be a
10 review of a measure concept, really looking at
11 importance, evidence, a lot of the issues you
12 guys really tangled with yesterday.
13 And then if you pass stage one you
14 get to stage two where we'll look at the fully
15 tested, fully specified measure. So the idea
16 is a lot of people invest a lot of money and
17 resources in developing measures that never
18 get past importance because the evidence isn't
19 there. There isn't a quality gap, et cetera.
20 So we're going to be doing
21 significant work on the submission form this
22 summer, in short, to be able to split it out

1 and think through that process. So maybe one
2 idea would be to actually have you take a look
3 at the questions, perhaps in more detail than
4 I think we did last time.
5 And just say, in light of this
6 conversation, what prospectively would you
7 want measure submitters to submit, at either
8 the concept stage and the fully specified
9 tested measures stage, that would allow you to
10 automatically come up with an algorithm that
11 says, yes, this measure should be classified
12 as disparity sensitive and prospectively
13 stratified.
14 Not that they have to answer today
15 but we're happy to engage in that. I would
16 find that incredibly useful because I think,
17 as much as it's wonderful to bring this to
18 you, we want to make this part and parcel of
19 the work of NQF.
20 So that every kind of measure
21 comes in, there is an assessment of that. And
22 it does sometimes depend on how, Ray Gibbons,

1 who is the chair of cardiovascular, who is the
2 Chief of Cardiology at Mayo, President of the
3 American Heart Association, could not have
4 been more strident.
5 Any measure without disparities
6 data up for maintenance was sent back. And
7 they needed to run it, get it back, or he
8 wouldn't look at it. And it was great. So
9 we're not trying to stick with that.
10 If your measure's been out there
11 for at least three years and you've got
12 nothing on how it's being used or what the
13 disparities are, well, you can find it. Bring
14 it back when it's ready.
15 And so part of that other process
16 is we'll move to almost a batch production
17 line for all of these areas. So we'll allow
18 measures to be submitted like every six months
19 across all these areas. So you don't have it,
20 go back out, finish it, bring it back in six
21 months.
22 So we'll have a lot more latitude

1 to have people just go away and get the data,
2 fix it, bring it back when it's ready. But
3 your input would be great there --
4 DR. NISHIMI: Does that help you,
5 Kevin?
6 MEMBER FISCELLA: Yes, it does.
7 I think it's really important because one of
8 the problems is that, I think, when many
9 people look for disparities and they don't
10 find them they may not publish it.
11 So a lot of this data is never
12 published. So then you don't know. Did
13 anybody look and find it or was it not
14 published?
15 But by asking people who are
16 coming in with new measures to begin
17 collecting that data and presenting it, I
18 think creates a much richer environment to
19 really assess where the disparities really
20 are. And helps me to feel more comfortable
21 about moving ahead, at least in the areas
22 where we know there are disparities and then

1 filling in as we go.
2 DR. NISHIMI: And the hope would
3 be that we would be through the portfolio in,
4 what, two more years. So in the greater
5 scheme of things that, for our processes, a
6 pretty short time frame. Francis?
7 MEMBER LU: Yes just a question.
8 In terms of question number two just from the
9 NQF protocol point of view, to what extent
10 would it be possible for those measures that
11 don't have any disparities data right now to
12 group them together, or maybe a sub-set of
13 those depending on what we decide, and label
14 them as potentially disparity sensitive based
15 on certain criteria, worthy of further
16 investigation or something.
17 Is that possible? Because I think
18 that still would be beneficial to the field
19 because this is such a new field. And the
20 work that's been done so far, that has
21 provided some assessment of these measures,
22 would really jump-start the whole process so

1 people don't have to start from scratch in
2 devising measures and all of that business.
3 But here's a set of things that
4 have reached a certain quality level that bear
5 further investigation. If that fits the NQF
6 protocol, I think that would be very helpful.
7 DR. NISHIMI: Yes, Helen's
8 indicating that. And certainly what it would
9 do is alert the measure stewards of those
10 particular measures, that there is an
11 expectation, when you come in to have your
12 measure re-reviewed for maintenance, you
13 really need to come in with the data. Okay,
14 any other thoughts on the assessment? Nicole?
15 MS. MCELVEEN: So next step, so
16 immediately the first thing that we will be
17 doing is reviewing the RAND measure, as I
18 mentioned earlier.
19 And what I would like to do is
20 provide the materials for that measure to the
21 group on Monday. And that's this submission
22 form and then the full survey itself for the

1 group to start to look through. And you will
2 have about a week to look through that.
3 And we want to just get a
4 conference call scheduled pretty quickly to
5 try and get that completed. The other
6 conference call that we definitely will have
7 is one that happens after we complete our
8 comment period.
9 So once the report goes out for
10 comment and we get those comments back we
11 review a good portion of those with the
12 committee to get your feedback on how we
13 should respond to certain comments.
14 Many of those we do defer to the
15 measure developer to answer because they're
16 usually the ones who know the response to
17 those questions. And there probably will be
18 instances that we'll need to get feedback from
19 the group.
20 And the measure developer will be
21 making changes only to that one measure, again
22 the measure addressing qualified interpreters.

1 That change will be made to that. And I
2 think that's it on the process side of next
3 steps.
4 The other piece I wanted to go
5 through with the group is around our time line
6 for moving forward. Our comment period is
7 scheduled. It's a 30 day period. It's
8 scheduled to open in May.
9 The dates listed, Adeela, sorry,
10 you guys have no clue what I'm talking about.
11 Let's see, there we go. So looking at our
12 comment period, again, is going to be from
13 April to May. Conference call in, looks like
14 the third week of May to review those
15 comments.
16 What then happens next is we go
17 out for an NQF member vote. That's a 15 day
18 period for members to vote on the measures.
19 We traditionally have a pre-voting webinar.
20 That's just an opportunity to
21 reach out to all stakeholders and all groups
22 to let them know that this report is coming

1 out for vote, to answer any questions that may
2 arise before that vote period happens.
3 And then later this summertime,
4 and then into August, is when we'll conclude
5 the project. And that will happen with a CSAC
6 decision. The CSAC will review our set of
7 measures and endorse the measures that they
8 feel are appropriate. And the board ratifies
9 that decision and then we have an appeals
10 period in August.
11 So the important thing that will
12 happen immediately following this meeting will
13 be the RAND measure will be circulated to you.
14 I will also circulate a survey that will poll
15 you for availability for conference call
16 dates.
17 We then will sort out the measures
18 assessment piece of the project and figure out
19 the best time to meet with the group to go
20 through the final steps of those. And, Grace,
21 did you have a question?
22 MEMBER TING: I did, so for the

1 gap measures that we identified earlier this
2 morning, is that just going to be future
3 iterations, we'll just leave those as gaps for
4 this round?
5 MS. MCELVEEN: Right, so that
6 information will be included in our report.
7 Did you want to say something about that,
8 Helen?
9 DR. BURSTIN: Actually Dennis made
10 a suggestion before he left that, just given
11 the brain trust here. It might be really
12 useful, perhaps, to have us send out that list
13 of measure gaps to you, that you all came up
14 with, and actually have people even sketch
15 them out a tiny bit more in terms of more of a
16 measure concept, so that we actually provide a
17 bit more information to the field in terms of
18 where, a bit more specificity to measure gaps.
19 MS. MCELVEEN: And the other thing
20 that I wanted to remind the group is
21 pertaining to the measures. If you have any
22 recommendations, particularly around the

1 measures that were not endorsed or that were
2 not recommended for endorsement,
3 recommendations for the developers, I know,
4 Colette, you had asked about that earlier,
5 just to please email me that information so I
6 can pass it on to them. Are there any more
7 questions? Kevin, did you have a question?
8 MEMBER FISCELLA: Yes, I just
9 wanted to get a sense of whether you feel
10 there's a clear enough consensus of where to
11 go here, given that this is going to be, I
12 guess, our last in-person meeting. Is that
13 right? And Liz's early comments on whether we
14 need to be clear or whether this is clear
15 enough.
16 DR. BURSTIN: I think we'll have a
17 better sense of that when we digest this. We
18 also could potentially, if you think it's
19 important, try to actually add another
20 meeting. But let's just see, in the
21 post-meeting analysis, how clear Robyn and
22 Nicole are feeling.

1 DR. NISHIMI: I do think that, in
2 the short term, the guidance that we got today
3 around the measures assessment was absolutely
4 excellent. And so it's clear the next steps
5 that can be handled.
6 Whether or not, once we get
7 through that and we see that we now have 300
8 measures that are in the no data category,
9 what to do about that.
10 Whether or not, as Helen said, we
11 have to go back and re-think our strategy, do
12 a couple conference calls with you that don't
13 prove to be fruitful and meet again, I think.
14 To me that is the biggest issue right now.
15 I think once we do those other
16 cross-cuts and sorts you'll be able to work
17 through those. And that's not the issue.
18 It's not entirely clear to me what we're going
19 to do with those other ones.
20 MEMBER JOHNSON: I just had a quick
21 question. You might have said this earlier
22 and I missed it. What happens with that

1 information about the gaps we identified?
2 Do you go out and search other
3 members, do you put out more of a directed
4 call for those things, or what happens with
5 those gaps we identified?
6 DR. BURSTIN: So they'll certainly
7 be in the report, as we were just talking
8 about. We can, again, you guys are connected
9 to a lot of the organizations where that
10 information might be useful. You should feel
11 free to distribute it if you think there are
12 developers thinking in this area of what to
13 work on next.
14 We can certainly work through
15 Ernie and others to see if there's some
16 opportunity there. But we do routinely have
17 measure developer webinars we conduct every
18 month. About 80 different developers come on
19 on a monthly basis.
20 So we do routinely try to, it may
21 be a very good opportunity, maybe on one of
22 these upcoming calls, to describe to them what

1 we're going to be asking to them, very clearly
2 up front, as they submit their maintenance
3 measures. And here are the gaps that were
4 clearly identified.
5 We've been trying to encourage
6 them not to spend a lot of energy on
7 look-alike measures as we like to call them,
8 like look-alike drugs, like same old measures,
9 different settings, same old measure, a
10 different slice of the population. But
11 actually, hopefully, invest those very limited
12 measures, all the dollars, where we need them,
13 like these gaps.
14 MEMBER CUELLAR: I'm sorry,
15 Elizabeth just triggered my memory. I
16 actually identified one other gap if you don't
17 mind, and that is persons with disabilities or
18 functional limitations.
19 The ability just to get a PCP, or
20 just general internal medicine type of care,
21 dental care, it's just the accessibility
22 issues are very, very wide.

1 And the other thing would be
2 transitional care for children with
3 disabilities transitioning to adult care. We
4 have children being seen by pediatricians that
5 are in their late 20s because they're not
6 enough physicians who will take children with
7 disabilities. It's an issue of accessibility,
8 a lot of issues surrounding that area.
9 DR. NISHIMI: Grace and Kevin,
10 Kevin?
11 MEMBER FISCELLA: In some cases
12 there are conditions like sickle cell anemia,
13 and management of pain in sickle cell anemia,
14 where it really almost exclusively affects one
15 group with a common ancestry.
16 And that wouldn't be a true
17 disparity, but it may be a disparity in terms
18 of the fact that this group has pain managed
19 less optimally than other groups who
20 experience pain. And so that's one potential
21 gap.
22 Another potential gap is the

1 correctional population, which gets very
2 little attention. And particularly in
3 healthcare that relates to treatment of
4 chemical dependency as well as mental health.
5 But the medical side is probably
6 not as bad but in terms of mental health and
7 substance abuse it's just abysmal. And of
8 course that's what gets people incarcerated to
9 begin with, oftentimes a behavioral problem.
10 But yet the care within this
11 group, that disproportionately affects poor
12 and minority people, there's very little
13 oversight, very little reporting and very
14 little public accountability.
15 DR. NISHIMI: Go ahead, Mary.
16 MEMBER MARYLAND: So I would echo
17 the issue around pain, not just in terms of
18 sickle cell anemia patients, it's a matter of
19 chronic pain, and as importantly, chronic pain
20 control at end of life. So those are really
21 big areas where frequently most providers and
22 institutions don't nearly adequately treat.

1 DR. NISHIMI: Anything else,
2 Nicole?
3 MS. MCELVEEN: Nothing else from
4 my end. I do really want to thank the group
5 again for being available, being attentive,
6 and helping us get through this information
7 over the last two days.
8 DR. BURSTIN: And again if you
9 have thoughts, big picture thoughts, of what
10 you think, in our role here, we could help
11 with in this field please let us know, thanks.
12 DR. NISHIMI: Thanks very much,
13 everyone, safe travels to those of you
14 traveling.
15 (Whereupon, the above-entitled
16 matter went off the record at 1:24 p.m.)
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21