

NATIONAL QUALITY FORUM
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HEALTHCARE DISPARITIES AND CULTURAL
COMPETENCY CONSENSUS STANDARDS
+ + + + +
MEETING OF THE STEERING COMMITTEE
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MONDAY, JULY 11, 2011

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The Steering Committee met at the Liaison Hotel, 415 New Jersey Avenue, NW, Washington, D.C., at 8:30 a.m., Dennis Andrulis and Denice Cora-Bramble, Co-Chairs, presiding.

PRESENT:

DENNIS ANDRULIS, PhD, Co-Chair

DENICE CORA-BRAMBLE, MD, MBA, Co-Chair

EVELYN CALVILLO, DNSc, RN, California State University (via telephone)

MARSHALL CHIN, MD, MPH, FACP, University of Chicago

LUTHER CLARK, MD, Merck & Co., Inc.

LOURDES CUELLAR, MS, RPh, FASHP, TIRR-Memorial Hermann

COLETTE EDWARDS, MD, MBA, CIGNA HealthCare

LEONARD EPSTEIN, MSW, Health Resources and Services Administration

DAWN FITZGERALD, MBA, Qsource (via telephone)

ROMANA HASNAIN-WYNIA, PhD, Northwestern University Feinberg School of Medicine

EDWARD HAVRANEK, MD, Denver Health Medical

Center

ELIZABETH JACOBS, MD, MAPP, University of Wisconsin

FRANCIS LU, MD, University of California,
Davis

MARY MARYLAND, PhD, MSN, BC, APN, Chicago
State University

WILLIAM McDADE, MD, PhD, University of Chicago
ERNEST MOY, MD, MPH, Agency for Healthcare
Research and Quality

MARCELLA NUNEZ-SMITH,, MD, MHS, Yale New Haven
Health System

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 PRESENT:

HELEN BURSTIN

HEIDI BOSSLEY

KRISTIN CHANDLER

NICOLE McELVEEN

ELISA MUNTHALI

ROBYN NISHMIMI

ALSO PRESENT:

JOEL WEISMANN, PhD, Disparities Solutions
Center, Massachusetts General Hospital

JOSEPH R. BETANCOURT, MD, MPH, Disparities
Solutions Center

I-N-D-E-X

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(8:54 a.m.)

MS. MCELVEEN: Good morning. Good morning. So now that we're all positioned a little more comfortably we can get started. And I apologize for the movement and the late start of the meeting.

My name's Nicole McElveen. I'm a senior project manager with the National Quality Forum and also heading up this project with a few other staff members from the National Quality Forum.

Good morning and welcome to the Healthcare Disparities and Cultural Competency Consensus Standards project. I want to make sure that everyone is here for this meeting because we do have also another NQF meeting going on across the hall for our Measure Applications Partnership.

We are going to jump right into the agenda and get started. A few logistics, as you all can see we have breakfast and

1 drinks in the back of the room. As you speak,
2 please be sure to use the mic. The meeting is
3 being recorded and the only way that we can
4 record is for the mic to be on while you're
5 talking. If you do have questions throughout
6 the meeting, our normal protocol is for you to
7 place your name card upright, allowing the
8 co-chairs and other folks to be aware that you
9 do have a question, if you do, during the
10 meeting.

11 And I think that's it for
12 logistics. I'm going to -- oh, let me just
13 tell you who else -- we're here with other
14 staff. Behind us on the table we have Elisa
15 Munthali, who you all may have been
16 communicating with, and also Kristin Chandler
17 is the project analyst. And I will let the
18 co-chairs introduce themselves.

19 CO-CHAIR ANDRULIS: Good morning
20 all. It's good to be back at an NQF meeting
21 once again. For me, this is the second time
22 around. I also think somebody thought it was

1 a good idea to pair Dennis and Denice
2 together. This is a first for me so you'll
3 have to be a little bit precise if you're
4 addressing us by our first names.

5 I just wanted to mention one or
6 two things from the conference call that to
7 keep in mind as we go through the couple of
8 days here. This meeting builds on a
9 significant body of work that's been done by
10 NQF before. There are a number of reports
11 that you have appended to the works that we
12 are looking at today.

13 So there is an opportunity to kind
14 of be added on, added on and integrated to
15 existing work as well as the hats off to the
16 folks who wrote the paper for this meeting,
17 Joel and Joe and others who wrote that
18 comprehensive and very thoughtful piece, give
19 us a lot of fertile ground to build on. So I
20 want to thank them for that great work.

21 And so as we go through between
22 the work that's been done before by NQF and

1 others and as well as the paper, but keep that
2 in mind as we have an opportunity here to not
3 only build on what they have done and take off
4 on variations on a theme, but set directions.

5 Agreement, consensus will be part
6 of this process, and something I remember from
7 that phone call is whether we're asking the
8 right questions being a good part of what we
9 need to consider here, as well as the
10 importance and feasibility of the points that
11 we'll be pursuing.

12 So with that I hand it over to my
13 colleague and say welcome.

14 CO-CHAIR CORA-BRAMBLE: So good
15 morning to all. Dennis and I are going to do
16 a bit of a team tag here. This was probably
17 the most difficult day for me to accommodate
18 in my schedule but I did not want to say no to
19 the, sort of the honor to be invited to be a
20 co-chair.

21 I'm actually in two different
22 meetings and I'm on call, starting at 9:00

1 a.m. so you will have to -- I will have to
2 apologize because I will be stepping in and
3 out. Dennis is going to do the heavy lifting
4 today and I'll have a little bit more leeway
5 tomorrow. So with that, I'm going to take my
6 9:00 a.m. conference call. It takes five
7 minutes, and I'll be right back.

8 CO-CHAIR ANDRULIS: I won't screw
9 it up.

10 MS. MCELVEEN: Great. A few other
11 things I wanted to mention, I just want to
12 make sure that everyone received an electronic
13 copy of the materials that were emailed out to
14 the group. We have also printed a copy of
15 those same materials and placed them at your
16 stations.

17 There was a small memo that was
18 accidentally left out. We have printed and
19 included a copy of that. It's about a
20 five-page document that was also placed at
21 your station. This memo is really a more
22 detailed copy of the agenda.

1 The agenda had a few questions
2 teed up for each section that we'll be
3 discussing. The memo had a little more detail
4 to it. So as we go through the sections of
5 the paper and the different discussions, you
6 may want to just reference the memo as needed
7 for that additional detail.

8 And so we're going to then move
9 into our disclosure of interests, and -- or
10 maybe introductions and then?

11 MS. BOSSLEY: Often, we've done
12 them at the same time.

13 MS. MCELVEEN: Yes.

14 MS. BOSSLEY: So I think it flows
15 together. So let me just give you a little
16 background on what we're about to ask you to
17 do. As you may remember, when you submitted
18 your materials you filled out a disclosure of
19 interest form. We're asking you to orally
20 disclose anything that may be relevant to the
21 work of this committee today. So we don't
22 need a full list of who you're a member of,

1 any of that, but any grants, any speaking,
2 anything that may be relevant to what will be
3 discussed, we're asking you to just state that
4 to everyone.

5 The other piece that I would just
6 remind everyone is you are here as
7 individuals, not representing the organization
8 you work for or who nominated you, something
9 we like to remind everyone. But let me stop
10 and see -- I'm seeing maybe some questions.
11 Does this make sense, what we're about to ask
12 you to do? Okay.

13 So just, I would do introductions
14 and then just go around and say if you have
15 anything to disclose. If you don't, feel free
16 to say, "I don't have anything to disclose."
17 Romana?

18 DR. HASNAIN-WYNIA: Does that
19 include what we've already listed or if we've
20 already listed it then can we just --

21 MS. BOSSLEY: We're asking you to
22 repeat.

1 DR. HASNAIN-WYNIA: Oh, you are.

2 MS. BOSSLEY: Yes.

3 DR. HASNAIN-WYNIA: Okay.

4 MS. BOSSLEY: So anything you
5 have, just briefly give a high-level what it
6 is and nothing more than that, just who it's
7 from and what the focus is, let's say, if it's
8 a grant. That's it. So not to put the chair
9 on the spot, but would you like to be the
10 person to start?

11 CO-CHAIR ANDRULIS: Yes. I'm
12 Dennis Andrulis. I have nothing to disclose.
13 And I am Dennis Andrulis.

14 MS. BOSSLEY: You are Dennis
15 Andrulis.

16 CO-CHAIR ANDRULIS: I did. I said
17 -- it's easily forgotten. Dennis Andrulis and
18 I have nothing to disclose.

19 MS. TING: Okay. Grace Ting. I
20 work for WellPoint. I'm not representing them
21 today. And I am currently receiving a grant
22 and I'm the lead PI for a Robert Wood Johnson

1 Foundation grant.

2 DR. CLARK: I'm Luther Clark. I'm
3 the Global Director for Scientific Affairs at
4 Merck Pharmaceuticals, located in, well, a
5 number of different places, Whitehouse
6 Station, Rahway and West Point, New York. I'm
7 a cardiologist by training. I've been at
8 Merck for approximately four years.

9 Prior to that, I was the chief of
10 cardiology at Downstate Medical Center in
11 Brooklyn and Director of the Brooklyn Health
12 Disparities Center. Other than being an
13 employee at Merck, I have nothing else to
14 disclose.

15 DR. JACOBS: Hi, I'm Liz Jacobs.
16 I'm at the University of Wisconsin, Madison
17 School of Medicine and Public Health. And I'm
18 not sure this is a conflict, but I'll mention
19 it anyways. I'm on Aetna's Racial Ethnic
20 Disparities Advisory Task Force, and I receive
21 an honorarium for being part of that.

22 DR. HASNAIN-WYNIA: Good morning.

1 I'm Romana Hasnain-Wynia, and I'm with
2 Northwestern University in Chicago. And I
3 don't believe I have any conflict of interest
4 or anything to disclose. I do serve on an
5 AHRQ Technical Advisory Panel on creating the
6 evidence base for disparities and quality, the
7 quality gap. And I do have a consulting with
8 the Henry Ford Health System. So I'll leave
9 it at that.

10 DR. NUNEZ-SMITH: Good morning.

11 I'm Marcella Nunez-Smith. I'm faculty at the
12 Yale School of Medicine and affiliated with
13 Yale New Haven Hospital. I am also PI on an
14 NIH grant to develop a measure of health care
15 discrimination. Other than that I have
16 nothing to disclose.

17 DR. OTSUKA: Good morning. I'm
18 Norman Otsuka. I'm a pediatric orthopedic
19 surgeon from the NYU Hospital for Joint
20 Diseases. I'm on the Diversity Advisory Board
21 of the American Academy of Orthopedic
22 Surgeons. I've taught some courses on

1 communication and diversity. I have no other
2 disclosures. Thank you.

3 MS. YOUDELMAN: Good morning. I'm
4 Mara Youdelman. I guess I should disclose I'm
5 a lawyer -- not a conflict but other issues
6 involved in that. I'm at the National Health
7 Law Program. Again, I don't think this is a
8 conflict but just in case, I'm the chair of
9 the Certification Commission for Health Care
10 Interpreters, which has developed competency
11 standards for assessing interpreters in health
12 care settings.

13 DR. WASHINGTON: Good morning.
14 I'm Donna Washington. I'm an internist at the
15 Greater Los Angeles Healthcare System and
16 UCLA. And I receive funding from the
17 Department of Veterans Affairs to conduct
18 health disparities research on determinants of
19 health care disparities within the VA Health
20 Care system. I'm also on the steering
21 committee for the VA Principal Deputy
22 Undersecretary for Health Group that's

1 addressing health disparities.

2 DR. HAVRANEK: I'm Ed Havranek.
3 I'm a cardiologist at the City Hospital in
4 Denver and on the faculty at the University of
5 Colorado Medical School. I have -- I'm PI on
6 one grant and a co-investigator on another
7 grant that looks at the effect of bias and
8 discrimination on health care outcomes.

9 DR. O'BRIEN: Good morning. I'm
10 Sean O'Brien. I'm a biostatistician at Duke
11 University Medical Center. I've been involved
12 with a couple previous NQF projects including
13 a measure testing task force and a couple of
14 hospital outcomes projects.

15 The group that I'm with at Duke
16 works with several medical professional
17 societies with their databases and so
18 frequently I'm involved with submissions to
19 NQF and so in past activities I've mentioned
20 my involvement with the Society of Thoracic
21 Surgeons database as a conflict.

22 MS. WU: Good morning. I'm Ellen

1 Wu. I'm with the California Pan-Ethnic Health
2 Network, and we receive a grant from Kaiser
3 Permanente. I think that's probably the big
4 thing to disclose.

5 MS. CUELLAR: Good morning, I'm
6 Lourdes Cuellar from TIRR-Memorial Herman --
7 thank you. Last year I did receive an
8 honorarium. I often speak on cultural
9 barriers to clinical research and last year I
10 did receive an honorarium.

11 DR. CHIN: I'm Marshall Chin. I'm
12 a general internist in health services
13 research at the University of Chicago. On the
14 conflict of interest statement, it was pretty
15 lenient in terms of I get low bar, so I'll
16 just go over the low bar.

17 Research grants from NIH, AHRQ,
18 Merck Company Foundation, Hartford Foundation,
19 Commonwealth Fund, American Diabetes
20 Association, Committees of the Midwest for
21 Clinicians Network, Institute of Medicine,
22 CMS, Robert Wood Johnson Foundation, ABIM,

1 AEEMC, Asian Association -- Pacific Islander
2 Health Organization, National Association of
3 Health Centers, VA, Indian Health Service and
4 American College of Cardiology, NCQA and a
5 number of general memberships that I don't
6 think are problematic.

7 DR. MARYLAND: Good morning. I'm
8 Mary Maryland. I'm faculty member at Chicago
9 State University and a nurse practitioner with
10 a private company. I have no disclosures.

11 DR. EDWARDS: I'm Colette Edwards.
12 I'm a gastroenterologist. Until very recently
13 I was with Cigna Healthcare as their national
14 medical director for health disparities, and
15 I have nothing to disclose.

16 DR. LU: I'm Francis Lu. I'll
17 disclose I'm a psychiatrist from UC Davis, and
18 I have nothing to disclose.

19 MR. EPSTEIN: I am Len Epstein.
20 I'm senior advisor for Clinical Quality and
21 Culture at HRSA, Health Resources and Services
22 Administration, and I don't have anything to

1 disclose.

2 DR. CORA-BRAMBLE: I'm Denice
3 Cora-Bramble. I am a professor of pediatrics
4 at George Washington and I'm a senior vice
5 president at Children's National Medical
6 Center. In terms of issues to disclose I was
7 -- I've been a chair of an advisory board for
8 Pfizer. I am a fellow of the Academy of
9 Pediatrics and also a consultant. I am a
10 member of the DC Physician Advisory
11 Subcommittee for Unison/United Health Care,
12 treasurer and board member of the Academic
13 Pediatric Association.

14 MS. BOSSLEY: Okay. Is there any
15 questions that you have for your colleagues?
16 Anything you wanted to discuss? Typically
17 it's no. I would say the reasons that you
18 listed are exactly why we've asked you to be
19 here, so this is a good thing, but we do like
20 to run through this in case there's any
21 concerns. I'm going to leave and go to the
22 next meeting so please don't be offended as I

1 walk out. Thank you.

2 DR. BURSTIN: I'll just add my
3 welcome. I'm Helen Burstin. I don't usually
4 sound like this. I do live with small viral
5 vectors known as children. I'm the Senior
6 Vice President for Performance Measures at
7 NQF. Great to see so many familiar faces, and
8 thank you all for being here.

9 We really view this as being an
10 incredibly important piece of what NQF can do,
11 and I think we really want to build on the
12 work that Dennis and others have done on our
13 previous Disparities Committee to really think
14 through what we should do prospectively as a
15 measure comes to us, to think through how we
16 handle it, should it be something we should
17 consider, always being stratified as an
18 example as you talked about in the report.

19 So we really look forward to your
20 guidance. We really do see this as something
21 we will take from this committee and just
22 build into all of our committees going

1 forward. So, thank you.

2 MS. MCELVEEN: I am going to do a
3 brief introduction and recap. Some of this
4 information you did receive during the
5 orientation call, and for those of you who
6 weren't able to call in, it will be new for
7 you. You don't have a copy of the slides, but
8 they are projected right behind you.

9 For folks who have laptops, not
10 too many in the room, but we do have Internet
11 access if you do have a laptop. We have a few
12 cards that have the user name and password and
13 we'll pass those around.

14 DR. BURSTIN: User name is laley,
15 L-A-L-E-Y, and the password is 00800, and it
16 works.

17 MS. MCELVEEN: And we have
18 introduced ourselves. This is the main
19 project staff.

20 MS. NISHIMI: Hi, I'm Robyn
21 Nishimi. I was the founding Chief Operating
22 Officer for NQF and now I'm a consultant

1 helping NQF with this project. Pleased to
2 have you on board.

3 MS. MCELVEEN: So again, the main
4 purpose of the project, we are looking to
5 establish recommendations for approaching
6 measurement of health care disparities across
7 settings and populations, and to also then
8 endorse a set of consensus standards for
9 measuring and publicly reporting on
10 disparities and cultural competency.

11 And this particular project, we do
12 have it broken up into two specific phases.
13 The first phase, which we're working on today,
14 is focusing on reviewing a very comprehensive
15 commission paper which will help us begin to
16 establish that approach for measuring health
17 care disparities.

18 And the second phase consists of
19 our traditional consensus development process
20 in which we will review and look at a set of
21 consensus standards to hopefully provide
22 recommendations for endorsement.

1 Our timeline across the two
2 phases, our meeting obviously is today, July
3 11th and 12th. Following this meeting and the
4 recommendations we receive from the committee,
5 the commissioned paper will go out for what we
6 call public and member comment. That's a time
7 that we allow our members and the public to
8 provide specific comments on the content of
9 the paper. And we're looking to finalize that
10 paper and to finalize the recommendations of
11 the committee a little bit later this year in
12 September.

13 Concurrently happening will be a
14 call for measures. We're hoping to launch the
15 call for measures as soon as possible. So
16 August is the start date for that call for
17 measures to be launched, allowing measure
18 developers to submit measures for
19 consideration.

20 Following that call for measures,
21 which will end in October, the NQF staff does
22 a preliminary screening of those consensus

1 standards before they're presented to the
2 committee. So we're looking at a second
3 in-person meeting where the committee will
4 review those consensus standards and provide
5 recommendations for endorsement in December,
6 early January.

7 So we don't have an exact date
8 yet, but as we progress throughout the project
9 in the coming month or so, we will have a
10 better sense of a more exact date because I
11 know that's a busy time with the holidays.

12 Finally, following that second
13 in-person meeting, we do continue on with our
14 traditional process of consensus where we do
15 have the standards posted for comment, as well
16 as a voting period. And looking to wrap up an
17 endorsement in June of 2012.

18 So quickly, I know you all are
19 probably familiar with this, but just wanted
20 to quickly recap some of our historical work
21 that NQF has done on disparities to date.
22 Began about 10 years ago in 2001 when we had

1 a small workshop with some key experts who
2 really helped NQF begin to think about health
3 care quality for minority patients.

4 And out of that workshop were ten
5 specific recommendations that were used to
6 engage stakeholders to begin to think about
7 disparities and health care quality for
8 minorities.

9 Following that work, we have our
10 Disparities-Sensitive Measures project for the
11 ambulatory care setting. During this project
12 we did endorse 35 disparity sensitive measures
13 appropriate for the clinician level. You all
14 do have a full copy of this report in your
15 materials.

16 And finally, most recently, we did
17 a project on cultural competency where we
18 endorsed a framework and 45 preferred
19 practices around cultural competent care.
20 I've provided the executive summary of that
21 report with your materials. We are, of
22 course, happy to provide the full

1 comprehensive report for that as well.

2 I'm going to pass over this. This
3 is an outline of the commission paper, which
4 we'll be getting an overview of that paper
5 briefly.

6 So the main meeting goals today
7 are: first, we want to talk about
8 recommendations for identifying disparity
9 sensitive measures. We also want to then
10 review, once we have those recommendations, on
11 applying that to our current NQF portfolio of
12 measures.

13 We also want to seek
14 recommendations, again, on methodological
15 considerations for measuring disparities. And
16 finally, an approach on how NQF can really
17 look at measuring disparities prospectively.

18 So with that, I am -- oh, I just
19 remembered, I did not give my audience and
20 team from Massachusetts General Hospital a
21 chance to introduce themselves. And before
22 you do, I'd just like to allow the folks on

1 the phone, if there's anyone on the phone who
2 has called in, either as a committee member or
3 as an audience member, I'd like to give them
4 a chance to introduce themselves.

5 MS. CALVILLO: Can you hear me?
6 Evelyn Calvillo.

7 MS. MCELVEEN: Okay.

8 DR. WEISSMAN: Do you want me to
9 repeat it? Joel Weissman, health policy
10 researcher at the Mongan Institute for Health
11 Policy.

12 DR. BETANCOURT: And Joe
13 Betancourt, Director of the Disparities
14 Solution Center at Mass General Hospital.

15 DR. CLARK: What's the planned
16 distribution of the white paper once it's
17 completed?

18 MS. MCELVEEN: We don't have a
19 specific distribution plan. I mean, it's
20 something that will remain intact with the
21 project, obviously. It will be available for
22 the public and the members for viewing. Did

1 you have a specific question around the
2 distribution of the paper?

3 DR. CLARK: It was more in the
4 context of how available and what kind of
5 awareness would be made that this exists?

6 MS. NISHIMI: As part of our
7 process, the paper will be posted and
8 available to NQF members and the public on our
9 website. And the authors are free to publish
10 it in what form they, you know, may wish to
11 submit it to a journal as well.

12 MS. MCELVEEN: Yes?

13 DR. CHIN: Could we go back to the
14 meeting goals slide, please?

15 MS. MCELVEEN: Sure.

16 DR. CHIN: So my question has to
17 do with sort of both this meeting as well as
18 more generally, this charge to the committee,
19 when you look at the four different bullets
20 there, the first three generally have to do
21 with measurement and the fourth is broader in
22 terms of an approach for addressing

1 disparities.

2 One of the very nice things about
3 Joel and Joe's paper was it talked about those
4 issues but then talked a lot then about
5 implementation in terms of, you know, not so
6 much what incentives you might build into the
7 system to reduce disparities as well as issues
8 regarding trying to avoid unintended
9 consequences. And in many ways those latter
10 two parts are at least if not more important
11 than sort of the measurement issues.

12 And so I'm wondering to what
13 extent are we supposed to concentrate on just,
14 like, just the good measurement issues and the
15 list of disparity measures versus that second
16 and third parts that Joel and Joe also talk
17 about, in terms of incentivizing? And then
18 design a system so that you avoid bad things
19 happening?

20 MS. MCELVEEN: That's a good
21 question. We have tried our best to sort of
22 lay out on the agenda an appropriate timeline,

1 timeframe for achieving all of these goals.
2 But recognizing that some kind of rise to the
3 top more than others.

4 So the main focus is first to
5 really look at the guidelines for identifying
6 disparity sensitive measures and to really
7 concentrate, again, on the methodological
8 considerations around disparities measurement.

9 We do also have a good portion of
10 our day tomorrow that will allow us to talk
11 about some of the other considerations that
12 you had mentioned and getting a lot of key
13 recommendations on more of the broader issues
14 for disparities measurement. Did you have a
15 comment as well?

16 DR. BURSTIN: Just one thing to
17 add to that. I think that that fourth one,
18 again, is still, as I read it, still kind of
19 an insider NQF question for you, in some ways.
20 Obviously it's a bigger question than that,
21 but I think in some ways we'd like to have you
22 help us understand as a measure comes to NQF

1 in any project, cardiovascular, surgery,
2 whatever the case may be, what kind of
3 information should they have to submit on the
4 submission form, for example, about evidence
5 of disparities? What should be submitted by
6 the three-year mark when the measure's been in
7 use to justify it?

8 It's those kinds of issues where
9 you don't want to have to go back
10 retrospectively, as you're going to help us
11 think through tomorrow, and say this is
12 disparity sensitive, this is disparity
13 sensitive, but instead, think through
14 prospectively how we do this.

15 So just as an example, the Child
16 Health Quality Committee this past year looked
17 at a measure of low birth weight. And the
18 committee immediately went, ooh, this is a
19 measure really hard to look at in the
20 aggregate, it was a population health level
21 measure, said this is one that should always
22 be stratified.

1 And it was one of those things,
2 again, made us think that we needed to have
3 some logical process where a committee looks
4 at something and says: this is really high
5 priority. This is a measure that should never
6 be looked at unless you have the strata to be
7 able to look for disparity. So that's kind of
8 what we're thinking, if that helps.

9 MS. MCELVEEN: Okay. Any more
10 questions? So we're going to move into a
11 presentation from Mass General on the paper.

12 DR. WEISSMAN: Great. Oh, do we
13 have a clicker for the -- to advance the
14 slides?

15 MS. MCELVEEN: You can cue me to
16 advance them. I'm the clicker.

17 DR. WEISSMAN: You're the clicker.
18 All right. Thank you very much. We're very
19 honored to be here today and before I begin
20 I'd like to just acknowledge our co-authors.
21 This was really a team effort of many of the
22 staff and friends of the Disparities Solutions

1 Center, including Alex Green, Gregg Meyer,
2 Aswita Tan-McGrory, who's in the room with us,
3 Jake Nudel, Jessica Zeidman, and Emilio
4 Carrillo. Next slide?

5 The purpose of this report, as we
6 understood it, was to provide guidance to the
7 NQF steering committee charged with selection
8 and evaluation of disparity sensitive
9 measures. And it really is all about providing
10 guidance from what we learned from the
11 literature and from our experience in working
12 together on a number of disparity sensitive
13 issues.

14 The expertise in this room
15 obviously is very impressive and so we don't
16 mean to in any way say that this is the way
17 something has to be done. It's really to
18 raise issues and hopefully to foster some
19 discussion going forward.

20 The second purpose is to describe
21 methodological approaches to disparities
22 measurement, which we spent a fair amount of

1 time, and to identify some cross-cutting
2 measurement gaps in disparities.

3 I also want to just make a couple
4 comments about some terms. We talk there are
5 -- people talk about health disparities which
6 really focus on health status and outcomes and
7 raise a lot of issues about the accountability
8 of the provider.

9 This report is more focused on
10 health care disparities. We rely on the IOM
11 definition of racial-ethnic disparities in
12 quality that are not due to access-related
13 factors, clinical need, preferences or
14 appropriateness. So it's really more about
15 the provision of care rather than thinking
16 about disparities in general, at least from
17 the perspective of this report.

18 I think, though, in terms of those
19 bullets that Marshall mentioned earlier, it
20 may be that you want to extend that to
21 reduction of health disparities generally.

22 Also, early on in the discussions

1 that we had about beginning this report, we
2 decided to focus on racial, ethnic and
3 language proficiency disparities. We did that
4 not because other disparities with women, the
5 disabled, gay and lesbian populations, there
6 are a number of other populations that exist
7 that have and experience disparities, but we
8 felt like the evidence on racial, ethnic and
9 language disparities were a little bit more
10 developed.

11 The efforts to develop measures on
12 other populations are in the developmental
13 phase, and we thought that there was plenty to
14 write just on those populations, and so we
15 decided to limit our comments to those. Next
16 slide.

17 The outline of the report and what
18 we're going to talk about today is we're going
19 to do -- we're going to talk about background
20 on racial/ethnic disparities and data
21 collection. Joe -- we'll do kind of a tag
22 team approach -- Joe will do numbers one and

1 two.

2 Then I'll take over and talk about
3 disparities, measures and indicators and some
4 methodological approaches and then hand it
5 back to Joe to wrap up with quality
6 improvement and then public reporting and some
7 of our policy recommendations. Next slide?

8 DR. BETANCOURT: Great. Well, I
9 want to thank everybody so much for giving us
10 this opportunity to put this together.
11 Hopefully, it was some good bedside reading
12 for you all at some point. It was, I think,
13 went into a lot of different places and again,
14 as Joel mentioned, food for thought.

15 It's humbling to get a chance to
16 be with you all. It's rare that I think we
17 all get a chance to be together and tackle
18 these issues, so I thank you for your time and
19 look forward to sharing some of our thoughts.

20 Background, quite simply, in the
21 paper we tried to make the case for why this
22 is important, the impact of disparities on

1 cost, quality and safety, and then really
2 highlight the fact that when we think about
3 measurement, we clearly see that our ability
4 to really measure disparities is going to be
5 the foundation for any interventions to
6 address them.

7 And so we talk about the fact that
8 even on the aspect of data collection,
9 race/ethnicity data collection, we have a long
10 way to go. And then taking it to that next
11 step of measurement is what we're looking at,
12 but certainly the key part of the foundation
13 for disparities development and intervention
14 development. Next slide, please?

15 We tried to put up front in the
16 paper as well a bit about data collection. In
17 this room we have some of the top talents in
18 the people who have been working on this since
19 Day One, particularly Romana and others who,
20 I think, have really set the tone nationally
21 for this issue.

22 We chose to really lean on the

1 most recent IOM report on race, ethnicity and
2 language collection, and so we summarize the
3 particular categories and approaches that that
4 report has set forth, but really also endorse
5 efforts of NQF, HRET and other efforts that
6 have, I think broke significant ground here.

7 We just pasted in here what the
8 selection criteria, or the data collection
9 criteria are and the approach. I will mention
10 that we highlight in the paper the conundrum,
11 upcoming conundrum, I think we're going to
12 face around multiracial populations and how
13 we're going to need to sort that out.

14 We tried to talk a little about
15 the importance in our learnings over the last
16 five to seven years around data collection and
17 training of registrars, training of folks who
18 are gathering this information, how to collect
19 it sensitively, how to do public awareness
20 campaigns. A lot of information there that I
21 think that we're going to need to highlight.

22 Joel has done a lot of work around

1 this topic of indirect estimation and studied
2 it quite a bit. We talk about the gold
3 standard being collecting the information from
4 the patient, but really needing to think about
5 issues around indirect estimation, surname
6 analysis, geocoding and the like that might be
7 used in the shorter term.

8 And then finally really thinking
9 about how to kind of hardwire this work into
10 where we're going with HIT and meaningful use
11 and all these other issues. So those are some
12 of the key things we wanted to cover. Next
13 slide, please?

14 We also provided here the criteria
15 for data collection around language
16 proficiency, with the caveat that the IOM
17 really talks about the importance of local
18 customization of language categories so that
19 those might be different depending on where
20 you are. So that was the background and the
21 data collection piece.

22 I'll turn it back over to Joel,

1 who will cover, again, sections three and
2 four. And I'll close this out with an
3 overview of kind of lessons learned and some
4 other key policy pieces.

5 DR. WEISSMAN: Thanks, Joe. Next
6 slide? Actually, back up one and just to
7 follow up with the data collection
8 recommendation, directly reported race,
9 ethnicity and language is the preferred
10 method, as Joe said. We need to solidify and
11 support the infrastructure for race, ethnicity
12 and language data collection. Joe mentioned
13 the clear guidance from IOM.

14 And then we just felt like, in the
15 short term, where direct report of
16 race/ethnicity is not feasible, that indirect
17 estimation can be put into place immediately
18 and you can actually use it for a lot of
19 population-based analyses. So next slide?

20 And so now we sort of get into
21 some of the meat of the recommendations of the
22 report, and we wanted to start by saying that

1 a lot of work has already been done by the
2 NQF. And that when we reviewed that work, you
3 know, we basically came out and said that we
4 certainly endorse the guiding principles from
5 the 2008 NQF report, National Voluntary
6 Consensus Standards for Ambulatory Care.

7 And they listed these five
8 principles, prevalence, impact of the
9 condition, impact of the quality process, was
10 there a quality gap, and the ease and
11 feasibility of improvement of quality process.
12 And what's sort of not stated there is each of
13 those principles relates to minority
14 populations, not just populations in general.

15 But that being said, we thought
16 that prevalence and quality gap were two
17 things to really be highlighted. That you
18 would not want to have a condition, whatever
19 that may be, that might be disproportionately
20 prevalent among a minority population and not
21 consider that for some sort of disparity
22 measurement.

1 And then the quality gap, if we go
2 to the next slide, our recommendation is that
3 if you look at all of the NQF measures, and I
4 guess there are around 700 right now, of
5 quality of care for ambulatory,
6 institution-based settings, disease-specific
7 measures, cross-cutting measures, that we just
8 felt like they should be crosswalked with the
9 literature on known areas of disparities.

10 In particular, the AHRQ
11 disparities report has a lot of information on
12 that, but other areas of disparity -- other
13 known sources of literature as well. And any
14 of the NQF measures that can be matched to
15 known disparities should basically be
16 considered disparity sensitive measures.

17 And then finally, we filed this
18 report and we mentioned this in the report in
19 section five, but just to talk about that now
20 is that we ought to integrate these
21 recommendations with the National Priorities
22 Partnership and the Measurement Applications

1 Partnership because there are a lot of other
2 efforts going on right now to develop measures
3 for health care reform and other purposes that
4 ought to be integrated with these activities.
5 Next slide.

6 This is something which we thought
7 would help explain how the section three on
8 measure selection is organized and structured,
9 and we think that it's worth thinking about
10 this in terms of an algorithm. This actually
11 came about as well with some of our
12 discussions with NQF.

13 But if you think about it, first
14 you might think about known disparities that
15 exist either currently or in the past for
16 specific or similar measures that currently
17 exist among those 700 measures.

18 So you look at the 700 measures
19 and then maybe you've already collected race
20 and ethnicity data and if there are known
21 disparities in the literature or on the data
22 that you collect, then obviously it's a --

1 then we think it should be a disparities
2 measure.

3 But there may be examples where no
4 data exist or where the data are not
5 sufficiently stratified by race and ethnicity
6 or the data exists and maybe at this point
7 show no disparities, but it may be that
8 there's a problem with the sample size or
9 maybe there's a problem with actually how we
10 measure it.

11 And in those cases, we develop
12 some, again, mostly from the literature but
13 some new criteria that we think ought to be
14 considered for thinking about current measures
15 or measure development in the future. And the
16 reason is that based on the experience of our
17 doing research in this area and looking at the
18 literature, where you tend to find disparities
19 are in these categories.

20 So for example, care with a high
21 degree of discretion: you tend to find more
22 disparities among vulnerable populations than

1 in care, for example, the contrast would be
2 care that is highly evidence-based with a lot
3 of consensus on what to do.

4 Some of the work that I've done
5 with Romana looking at the Health Quality
6 Alliance data, you know, aspirin after
7 discharge. If there's -- or with AMI, if
8 there's already a lot of consensus on what to
9 do, you're not going to necessarily find that
10 many disparities.

11 Communication-sensitive services
12 tend to find more disparities than others.
13 Obviously, especially with patients of limited
14 English proficiency, but also with racial and
15 ethnic minorities that may have various
16 cultural issues to deal with. I would mention
17 here tobacco cessation for congestive heart
18 failure patients.

19 The third area would be lifestyle
20 changes, diabetes self-management, wherever
21 it's required to try and gauge the patient
22 beyond the doors of the office where the

1 clinician is seeing that patient face-to-face.
2 If you're looking at measures about lifestyle
3 changes, those tend to be areas where you're
4 likely to find more disparities.

5 And then outcomes rather than
6 process measures, kind of related to this
7 lifestyle change and patient engagement issue,
8 but again, once you deal with situations in
9 the communities or family life or other kinds
10 of cultural impacts, there are likely to be
11 differences. You're likely to find more
12 differences in outcomes rather than in process
13 measures.

14 And then we also at the end, and I
15 think this last bullet almost ought to be
16 added as a fifth criteria, and that is to
17 really consider measures along the clinical
18 pathway. A lot of times these process
19 measures, you know, you tend to sort of pick
20 ones that are available and that are well
21 vetted, but then you miss steps along the
22 clinical pathway that really might impact

1 outcomes down the line.

2 And the example that we give in
3 the report is renal transplant, where it's not
4 just about referral to specialists, it's
5 about, you know, are they able -- if they get
6 referred for transplant, are they able to get
7 the workup? If they get the workup, are they
8 able to understand many of the bureaucratic --
9 and follow and be able to afford in some
10 cases, many of the bureaucratic requirements
11 to actually receive a transplant. And then do
12 they actually receive a transplant?

13 But there are other conditions, we
14 believe, that have a number of steps along the
15 clinical pathway and that it's important to
16 consider other steps. And this is where I
17 think the clinical expertise on this panel
18 would really come into play.

19 And then the final category that
20 we talk about is where we believe that in the
21 literature has started to show where
22 disparities may exist, but there really are no

1 good quality measures that exist at this
2 point.

3 And if I go to the next slide, we
4 call these disparity sentinel measures. And
5 they're created specifically as measures where
6 research has shown that disparities exist.
7 They're developed based on a review of the
8 literature.

9 And the best example that comes to
10 play, and we do this at Mass General Hospital,
11 is there's been a fair amount of research that
12 has come about recently on pain management in
13 the emergency department, and yet, there
14 really are no good quality measures out there
15 that are being used.

16 And so at Mass General now,
17 they've started to do some chart reviews.
18 They've started to measure and they started to
19 collect these data. And they're monitoring it
20 just like you would monitor any sort of other
21 sentinel type of event.

22 So this is where we think that

1 it's another tool to, I guess, put in the
2 toolbox and to think about measures that
3 should be developed and maybe aren't at this
4 point. All right, next slide.

5 And then, you know, in trying to
6 -- when we started looking at and reviewing
7 some of the 700 measures for NQF, it was a
8 little overwhelming, and we tried to make some
9 sense about it. And this was a categorization
10 that we came up with that we think may have
11 some value, just in terms of dividing up the
12 types of disparities measures.

13 It's not really criteria; these
14 are categories, and these are explained in a
15 little bit more detail in the report. But
16 basically ones that focus on practitioner
17 performance, ones that focus or are based on
18 consumer surveys of patient experience, then
19 you go to health care facility performance,
20 ambulatory care-sensitive conditions kind of
21 get their own category, cultural competency
22 and patient-centeredness. There's a lot of

1 overlap between these categories, but we
2 thought that it would be a useful way to sort
3 of think about it and group some of the
4 measures.

5 And then what we actually started
6 to do with it that we recommend that perhaps
7 NQF do this in a systematic fashion, if we
8 look at the next slide, is to go through each
9 of these, each of the measures.

10 And then -- so here's an example
11 where we started with practitioner performance
12 measures, and first of all determine some of
13 its characteristics, so the column three is
14 the type of measure, whether it's
15 condition-specific or cross-cutting, and try
16 and understand a little bit more about the
17 root of the potential disparity.

18 Whether it really -- whether it
19 seems like the literature suggests that it's
20 something that the provider can do that -- or
21 that may be responsible for some of the
22 disparities, whether it's more about patient

1 engagement and patient-based, whether it's
2 systemic or whether it has to do with
3 basically affordability issues, such as health
4 insurance. And then think about whether it's
5 structural, process or outcome. Next slide?

6 So now I want -- oh, yes, we can
7 have questions. Yes, go ahead.

8 DR. JACOBS: Sorry, just a quick
9 question. I wasn't sure what PM stood for in
10 the -- is it process?

11 DR. WEISSMAN: Process measure,
12 yes.

13 DR. JACOBS: Oh, okay. Thank you.

14 DR. WEISSMAN: Sorry, I know we
15 should have had a little key at the bottom.

16 DR. JACOBS: I was thinking
17 process but I wasn't sure. Thank you.

18 DR. WEISSMAN: Process, PM,
19 process measure, O is outcome and then S would
20 be structural.

21 DR. JACOBS: Okay.

22 DR. WEISSMAN: Sorry. Now we are

1 going to do the methodological approaches to
2 disparities measure, how to measure about --
3 measure and monitor and I was just having a
4 conversation before the meeting started and I
5 actually think that probably 95 percent or
6 more of people that do work in disparities,
7 especially in the clinical setting, don't
8 realize some of the complexities involved with
9 especially tracking things over time.

10 And I think that's where, you
11 know, it's you don't have kind of one point
12 that stays still. You've got a lot of moving
13 parts. And we cover all these sections in the
14 report. I'm going to go over just a few of
15 them given the time limitations in this
16 presentation.

17 So if we go to the next slide, the
18 first point, and I think this is potentially
19 one of the more controversial points that we
20 make is that when you're choosing a reference
21 point we're taking the position that the
22 choice of the reference group should be the

1 historically advantaged group.

2 There are other groups to
3 consider. The largest group, the group with
4 the best performance and so on, but we think
5 in reviewing the disparities literature that
6 actually there are some perhaps unintended
7 consequences if you don't choose the
8 historically disadvantaged group to the extent
9 that that could drive some resource
10 appropriations later on down the road. Next
11 slide?

12 And here's the, you know, the
13 class -- I teach this in a class every summer
14 and this is a slide I use that really displays
15 the differences and differences approach. You
16 know, the question is did black-white
17 disparities get better or worse between 2000
18 and 2010? And here's, you know, you can look
19 at the absolute difference or you can look at
20 the ratio, and the answer is really both.

21 Depending on how you do it, you
22 could say disparities got worse or disparities

1 got better. And the arithmetic is in the
2 report. I won't bother going through that
3 now, but if you go to the next slide the take-
4 home message is that absolute and relative
5 changes in disparities can yield different
6 conclusions on whether or not gaps are
7 closing.

8 And actually, I think you also
9 might, although we don't do it as much, but if
10 you compare institution to institution
11 depending on whether you look at changes over
12 time in terms of relative or absolute
13 measures, you could find the same sorts of
14 issues.

15 You have similar issues with
16 favorable versus adverse events. Again, you
17 know, did the patient get the service or did
18 they not get the service. You know, one would
19 be a difference maybe of 90 percent versus 92
20 percent. The other -- or let's say 98 percent
21 versus 96 percent, you know, and the other
22 could be a difference of two versus four.

1 One could be a difference of 200
2 percent difference. The other could be a very
3 small percent difference. Again, it's playing
4 with numbers, but it really makes a difference
5 when you report these sorts of things publicly
6 to find out that there's a twofold difference
7 or there's a 2 percent different really makes
8 a difference in terms of how it's seen in
9 public.

10 And so our recommendation is that
11 generally you need to calculate both types of
12 statistics. If they're consistent with each
13 other, fine, pick the one that's easiest to
14 report. But if they're not, if they conflict
15 and if they give you different messages then
16 I think at least in terms of reporting that
17 that needs to be noted somewhere.

18 And that it, you know, allow
19 readers to make their own interpretations
20 whether they think in this case a ratio is
21 more important than an absolute difference.
22 Kind of, it depends so much on the particular

1 clinical condition and the particular measure
2 that's selected. Next slide.

3 We go into some detail on paired
4 versus summary statistics. By pair-wise
5 comparisons I mean, you know, if you want to
6 look at black-white or Hispanic-white and what
7 happens is, if you have a lot of different
8 subgroups, that does not become very report
9 friendly, especially when you start looking at
10 changes over time and improvements. You get
11 a lot of different comparisons.

12 I can tell you that I worked with
13 Massachusetts on a state report card and, you
14 know, there are a lot of different measures
15 and the idea is that you want to make it as
16 simple and user-friendly as possible.

17 And so the big advantage of
18 summary statistics is that they can address
19 these issues by really taking a lot of
20 information and summarizing it in one number.
21 But, you know, unfortunately that has a lot of
22 disadvantages in the sense that it can obscure

1 important information, in particular,
2 directionality.

3 What we found in, for example, we
4 use a summary statistic for pay for
5 performance to reduce disparities in
6 Massachusetts, and in fact in a lot of
7 situations, the disadvantaged minority
8 population actually gets better quality of
9 care than the white population for a
10 particular institution. And yet that would
11 show up as a disparity that may not be
12 eligible for example for pay for performance.

13 So those sorts of things need to
14 be investigated. So pair-wise comparisons we
15 believe using the historically advantaged
16 group as the reference point, should be
17 checked to see if the summary statistic
18 reflects superior care received by the
19 disadvantaged group. And if so, you just need
20 to sort of consider the context of the report
21 and what the relevant policy goals are.

22 And they at least need to be made

1 explicitly because what happens with a lot of
2 these disparity indexes is that they really
3 are not as transparent and understandable
4 compared to some of the pair-wise comparisons
5 which are really right out there. So they're
6 useful, but they need to be explained in
7 detail we think. All right, next slide.

8 The next issue is sample size
9 considerations and, you know, clearly when
10 you, even on a national level, some of our
11 racial-ethnic minorities in large national
12 surveys can result in very small sample sizes.
13 The smaller the numbers, the more likely
14 disparities will reflect chance rather than
15 true differences.

16 And there are a number of
17 recommendations that we make that are pretty
18 commonly used in both research and in quality
19 reporting. Again, I won't go into them in
20 more detail other than to mention them here.

21 You can roll up categories. In
22 fact, generally when you look at subdivided

1 racial and ethnic categories, the idea is to
2 roll them up into those five OMB categories.
3 But sometimes, and you know I've done this
4 myself, minority versus non-minority, but you
5 know, when you do that, of course, again, the
6 danger is it obscures some of the potential
7 differences that may exist among subgroups.

8 You can use some of the summary
9 statistics or summary indexes that I
10 mentioned. You can also use composite
11 measures for quality measures. In other
12 words, instead of just the classic one is, the
13 composite measures that are reported for the
14 Hospital Quality Alliance, you know, you've
15 got five or six different measures for CHF or
16 five or six different measures for AMI. And
17 you can roll those up into a single composite
18 and that can help with some of the numbers
19 problem. And then you can combine data for
20 multiple years.

21 That being said, I think the other
22 point that we make in the report is that, you

1 know, for high stakes reporting you may have
2 to roll up numbers of minorities in order to
3 make them statistically stable. But at the
4 same time, for quality improvement purposes,
5 it may be worthwhile to look at those racial
6 and ethnic minority subgroups to see what's
7 going on.

8 It can be of interest to your
9 clinical providers and it can be interesting
10 to administration as well in terms of kind of
11 monitoring what's going on. But when the
12 numbers are small, the statistics just say
13 basically that you can't really use them.
14 Next slide.

15 Risk adjustment and
16 stratification, we spent a fair amount of time
17 on, and you know, basically case-mix
18 adjustment and stratification are ways to
19 avoid some of the --

20 CO-CHAIR ANDRULIS: Joel?

21 DR. WEISSMAN: Yes? Sure.

22 CO-CHAIR ANDRULIS: Could you hold

1 for just a second? You have a question.

2 DR. WEISSMAN: Oh, okay.

3 DR. CUELLAR: I have a question on
4 the subgroups.

5 DR. WEISSMAN: Yes, in the back?

6 DR. CUELLAR: Did you factor in
7 also geography? Just I'm from Texas and I
8 know, originally from San Antonio, and when we
9 look at San Antonio versus Houston, for
10 example, San Antonio the Hispanics are like
11 me. I'm a sixth generation, versus Houston
12 where there is a very large population of
13 Central Americans and it's really very
14 distinct in every aspect of health care.

15 So from that aspect I think that's
16 a very important point, the subgroups is very
17 important. So I don't know if you even looked
18 geographically because I know particularly
19 with the Central Americans, they're really now
20 migrating to different areas of the country.

21 DR. WEISSMAN: Yes, I mean I think
22 that's, you know, an excellent point and what

1 we say in there is that, you know, after you
2 get the five OMB categories then there are a
3 lot of approaches that exist to get into a lot
4 more granularity. And it's difficult to
5 settle on a granular list of racial and ethnic
6 categories that work everywhere in the
7 country.

8 And so the recommendation that we
9 make is exactly what you're saying. Depending
10 on the locality that you should -- after you
11 get, you know, make sure that it rolls up
12 again, but try and figure out what are the
13 categories that make sense for your particular
14 population.

15 Joe, do you want to --

16 DR. BETANCOURT: No, that's fine.

17 DR. WEISSMAN: Okay. So yes, I
18 would say that. So I mentioned that these are
19 ways to avoid punitive effects, especially
20 with pay for performance and other types of
21 high-stakes reporting that affect providers
22 with disproportionately large, poor and

1 vulnerable populations.

2 The issues there are that when you
3 tend to risk adjust, first of all, you really
4 obscure all the racial and ethnic or the
5 subgroup differences, and a lot of people are
6 a little bit concerned that it lowers the bar
7 in terms of if, if minorities are receiving
8 poor quality of care, somehow it excuses the
9 provider for that because you're risk-
10 adjusting based on performance elsewhere.

11 And then it also -- the other
12 disadvantage of risk adjustment is that it
13 allows providers to perhaps focus on the
14 majority population and improve quality of
15 care there without really improving quality of
16 care for disadvantaged populations. So there
17 are some issues.

18 Stratification, you know, its
19 biggest advantage is that it's more
20 transparent. To be honest, you're still in
21 some ways saying, well, you know, this is the
22 quality of care for minority populations and

1 we're going to compare those to other settings
2 and that may be better or worse than the
3 majority population. But at least it's
4 obvious in front of you what categories you're
5 looking at.

6 So for that reason mostly we
7 recommend that stratification should be
8 performed when there's sufficient data to do
9 it. And that risk adjustment, though, can
10 still be appropriate, especially when you've
11 got -- when performance is usually related to
12 outcomes or proxy outcomes that are highly
13 dependent on community factors beyond a
14 provider's control when you're really talking
15 about quality measurement. Next slide.

16 And now I'm going to turn it back
17 over to Joe.

18 DR. BETANCOURT: Yes, so just to
19 bring this to a conclusion here, we talked
20 about priorities and options for quality
21 improvement in public reporting and really see
22 NQF's kind of vision very well-aligned with

1 what we're trying to do with the
2 disparities-related work.

3 So we're trying to really, with
4 the development of these measures, achieve a
5 variety of things, monitor progress towards
6 disparities reduction, inform consumers and
7 purchasers, stimulate competition, stimulate
8 innovation and promote values.

9 To Marshall's point, we tried to
10 spend a lot of time kind of picking people's
11 brains and also looking at real world
12 experiences around kind of unintended
13 consequences, untoward consequences from this
14 work, and so we highlighted a couple of
15 different things, particularly issues that
16 have been covered both anecdotally and
17 otherwise around pay for performance and
18 public reporting that have particular
19 relevance to disparities.

20 So this concept of kind of
21 cherry-picking and lemon-dropping as a way to
22 make your measures look better, the rich get

1 richer so certain organizations who have more
2 resources are actually doing better around pay
3 for performance.

4 We talk about teaching to the test
5 and we give the example of a way that people
6 address measures by simply instituting
7 antibiotics for anybody who comes in with a
8 cough absent, you know, to make sure they get
9 their door to needle time right. You know,
10 could that be done around disparities-related
11 issues, gaming the system?

12 We talk a little bit about the
13 ability of minorities to benefit from kind of
14 this general QI versus targeted QI, and then
15 this growing field of recognition on kind of
16 between and within institution disparities.

17 Next slide, please?

18 We tried to touch a bit on kind of
19 what do we see out there right now? And on
20 the federal and state side we talked a bit
21 about how certain states, for example,
22 Massachusetts being one of them, has mandated

1 the collection of race, ethnicity, language
2 and highest level of education for all
3 hospitals and health plans.

4 And that has been a pretty good
5 experience now, although we haven't done as
6 well around moving towards routine monitoring
7 and measurement. But we do have hospitals
8 that have demonstrated that this information
9 can effectively be collected.

10 Health plans as well, we'll talk
11 more about health plans in a moment, but the
12 National Health Plan Collaborative, several of
13 the health plans who are here, have done great
14 work in this regard as well. And I think
15 those provide significant lessons learned.

16 We have seen some Statewide Health
17 Disparities Report Cards, but their primary
18 focus has been just stratifying health
19 outcomes by race-ethnicity, on occasion
20 looking at certain measures, but again, I
21 think there's something to be learned there
22 but perhaps kind of looking more at kind of a

1 general health outcomes prevalence and
2 epidemiology, less on particular measures.
3 And we might be able to learn, I think more
4 around statewide efforts in that regard. Next
5 slide, please.

6 From the standpoint of health
7 plans, again, National Health Plan
8 Collaborative being the optimal example, but
9 we do see certain routine collection of race-
10 ethnicity data collection continuing to be a
11 challenge for health plans for a variety of
12 reasons.

13 There's indirect estimation. We
14 have others who are doing some direct
15 collection, geocoding and surname analysis as
16 well. We have seen in some of our work that
17 local, smaller plans can kind of get data from
18 the state, get data from different places that
19 allow them to provide better profiles of their
20 member race, ethnicity and language as opposed
21 to some of the challenges that larger national
22 plans face. So something to keep in mind and

1 to explore as you go forward. Next slide.

2 We provide here an example of the
3 work that Aetna's doing going beyond
4 race-ethnicity data collection to the
5 development of their first Racial and Ethnic
6 Equality dashboard, which has a variety of
7 different elements including disease
8 prevalence and diversity around their
9 geographic market segments, stratification of
10 CAHPS and other quality measures that they are
11 now stratifying now and developing as an
12 annual report. Next slide.

13 From the standpoint of hospitals,
14 again, we see that hospitals have been -- some
15 hospitals have been able to create routine
16 disparities measurement and monitoring tools,
17 dashboards and/or reports. They have begun
18 primarily by taking off the shelf measures and
19 stratifying them by race, ethnicity and
20 language if that language is available.

21 And again, to Joel's point,
22 connecting these wires is very, very

1 challenging. It's not as easy as just, well,
2 let me take the core measures, let me take the
3 data and just kind of connect it. Oftentimes
4 these systems don't speak to each other.
5 They're not connected. Generating these
6 reports, there's a lot of devil in the
7 details, but it has been done.

8 A particular challenge, I think,
9 for hospitals has been small minority sample
10 size for particular conditions, limiting
11 statistically significant comparisons.

12 And we also highlight the
13 importance of an appropriate communication
14 strategy as we try to go public with
15 disparities reporting. There's a lot of
16 concern from hospitals and other organizations
17 that if we say that we're doing work in this
18 area, are our patients going to be concerned?
19 Are providers going to feel blamed? And so as
20 we move towards public reporting,
21 communications is going to be really
22 essential. Next slide, please.

1 We highlight some of the work that
2 we've been doing since 2007 at Mass General
3 Hospital where we have a disparities dashboard
4 release once a year that this is just the
5 executive summary.

6 It green-lights areas where we
7 don't have any disparities and we stratify our
8 national hospital quality measures, HEDIS
9 outpatient measures. And, as Joel mentioned,
10 we have a sentinel measure around pain
11 management in the emergency room for long bone
12 fracture. So we monitor that.

13 Orange, lighter areas are where we
14 see disparities nationally and we're exploring
15 them now, mental health and wait time for
16 renal transplantation. We are now stratifying
17 all-cause and ambulatory care-sensitive
18 admissions, CHF readmissions and patient
19 experience.

20 And then red light are areas where
21 we found disparities and developed
22 interventions, something that we think is

1 very, very important because as you go public
2 you need to communicate to the community that
3 if you found something, you're doing something
4 about it. Next slide, please?

5 We also publicly report so anybody
6 could go to MGH Quality And Safety and come
7 and take a look at our equity report, look at
8 our numbers and look at our improvement
9 stories. And again, we can provide that link
10 inasmuch as it might be helpful. Next slide,
11 please.

12 So I think we have -- we ended
13 with a series of questions related to policy
14 and dissemination. Clearly, we believe that,
15 when we move towards public reporting,
16 standardized measures that are easily
17 understandable and actionable are essential,
18 capitalizing on available measures used for
19 quality reporting is a great place to start.
20 OMB categories used and adapted over time with
21 capacity for local subgroup variation.

22 And then, again, when we debate

1 this issue of public reporting how should it
2 be used? Should it be used for payment
3 reimbursement or consumer choice, provider
4 incentives?

5 And this packaging piece is
6 really, really important. How do we explain
7 disparities to providers, the public,
8 organizations? Think about root causes, link
9 it to quality improvement in a way that
10 doesn't get people to shy away from or be
11 scared of doing work in this area, but instead
12 engaging and really seeing equity as a key
13 part of quality.

14 So that's the end of our formal
15 presentation. You can go to the next slide.
16 We're happy to answer any questions that you
17 all may have, and thank you so much for your
18 time and attention.

19 CO-CHAIR ANDRULIS: Thank you,
20 both, for the comprehensive and very, very
21 helpful review. We're going to enter the
22 question-comment stage now, and I'd just ask

1 you when you raise your cards, make sure I can
2 see them, so please feel free to get started.

3 And I'll get started with you. I
4 just have a couple of questions about whether
5 you had discussions about a couple points
6 which seem to dance around the edges of your
7 focus around social determinants. And as you
8 touch on that in lifestyle issues, which is,
9 to me, kind of like a broad opening in some
10 ways to that. And whether, because of the
11 close correlation of health literacy to a lot
12 of these issues of culture and language,
13 whether these were discussed and what context
14 you might put it in?

15 DR. WEISSMAN: Do you want to take
16 that first?

17 DR. BETANCOURT: Yes. So I mean I
18 think, you know, if you look at these measures
19 that NQF has already they really span the
20 gamut, right? You have something as simple as
21 asthma assessment that Joel highlighted which
22 is a very provider-based kind of piece. And

1 then you have others more outcome-related
2 where social determinants play a much larger
3 role.

4 I think what we're recommending is
5 that, you know, these are going to need to be
6 looked at in different ways and some of these
7 that have -- that we would think for certain
8 communities have a greater social-determinant
9 causal connection, then how can, you know, how
10 do we make those disparity-sensitive and what
11 are the appropriate pieces that you need to
12 put in place so that you can correctly gather
13 that?

14 It's critically important, no
15 doubt, but the measures, again, run the gamut.
16 Asthma assessment is something done in the
17 office. Something like some of these
18 outcomes, diabetes is the example we gave, you
19 know; that requires a lot more work and I
20 think that's something that's going to need to
21 be debated around focus and scope among this
22 committee.

1 DR. WEISSMAN: I was just going to
2 say, leave it to Dennis to really get at the
3 core issue of the unexplored areas in the
4 report. You know, we did kind of dance around
5 it and address it in a number of different
6 areas, and clearly the social determinants
7 tend to be more important for outcomes, but
8 even for process measures.

9 I was just reading an article
10 recently about racial and ethnic disparities
11 in TRICARE, the military health system, which
12 is, you know, supposed to be uniform care for
13 everybody, looking at asthma care for kids.
14 And they get sent different rates to different
15 specialists and they get different care even
16 within TRICARE. So even in process measures,
17 social determinants are important.

18 We make the case that if -- to
19 basically not adjust for social determinants
20 when reporting racial and ethnic disparities,
21 that even though it might be a mitigating
22 factor or an explanatory factor, that it

1 doesn't say that those disparities don't
2 exist. And that I think especially when
3 reporting to the public, people don't want to
4 say, well, you know, this group may have
5 disparities but if you adjust for health
6 insurance status, the disparity goes away.
7 You know, I don't think that is reality
8 because I think the disparity still exists.

9 I think the other side of the
10 coin, which we touch on a little bit, is in
11 how much to hold the provider responsible,
12 especially when it comes to high-stakes
13 reporting. And a lot of providers will say,
14 you know, you should adjust my patient
15 population for social determinants because
16 there may be communication issues, there may
17 be transportation issues, there may be all
18 these sorts of things which are more difficult
19 and therefore more costly for me to address.

20 And there's one recommendation
21 that we kind of threw in there that I've been
22 exploring recently, which says that, if that's

1 the case, then maybe what we ought to think
2 about doing is risk-adjusting payments to
3 providers.

4 In other words, if they have a
5 more difficult population, pay the provider
6 more based on their population, but then hold
7 everybody to the same standard in terms of
8 quality outcomes, which is something which I
9 don't think has been tried anywhere, but is
10 something that might be considered in the
11 future.

12 CO-CHAIR ANDRULIS: Thank you.
13 It's just something that I think as the group
14 goes along that there's clearly more of an
15 emphasis on these issues of social
16 determinants. You can see it reflected in the
17 health care law and it might be something for
18 the discussion along the way.

19 Why don't we -- for questions why
20 don't we go around the table starting with
21 Elizabeth and we'll just do a round for now
22 and pick up people as they are identified.

1 DR. JACOBS: Actually, mine's not
2 a question but an offer of a resource. So I
3 noticed that you talked about measuring
4 language in the report and that you weren't
5 sure about the best way to ask it, the two
6 questions, the OMB questions versus preferred
7 language.

8 And it turns out that Leah
9 Carliner and colleagues have done a really
10 nice paper actually showing the sensitivity
11 and specificity, excuse me, of using those two
12 questions and how to phrase it, and I will
13 email you that reference. I think that would
14 be an excellent thing to include because it's
15 really well done.

16 CO-CHAIR ANDRULIS: Thank you.
17 Norman?

18 CO-CHAIR CORA-BRAMBLE: Before you
19 go on, could you make sure that this -- one of
20 the staff persons gets the paper?

21 DR. JACOBS: You know what? I'll
22 send it to the whole group.

1 CO-CHAIR CORA-BRAMBLE: Okay.

2 DR. JACOBS: I'll just send it to
3 the whole group --

4 CO-CHAIR CORA-BRAMBLE: Okay,
5 great, thanks.

6 DR. JACOBS: -- the reference so
7 you can all have it if you're interested in
8 it.

9 CO-CHAIR ANDRULIS: Great, thank
10 you.

11 DR. OTSUKA: First of all, a
12 selfish comment, I'm just surprised on the
13 dashboard you don't include musculoskeletal
14 care or health as one of the major criteria,
15 especially with our aging population. I mean
16 what, there's -- I'm a pediatric orthopedist
17 but there are, like, 250,000 total hips being
18 done in the American population. So I'm just
19 surprised it's not one of the categories up
20 there with diabetes and asthma and fractures
21 and trauma, et cetera.

22 DR. BETANCOURT: In which

1 dashboard are you referring?

2 DR. OTSUKA: Well, you had one of
3 the dashboards with the six main health
4 determinants, asthma, cardiovascular disease,
5 one of your slides -- it was also with Aetna.

6 DR. WEISSMAN: Can we go back?
7 Let's just look at it. That one?

8 DR. OTSUKA: Go back. Go back.
9 There, quality measures. You're measuring --

10 DR. BETANCOURT: Oops, come back
11 now.

12 DR. OTSUKA: -- asthma and --

13 DR. BETANCOURT: So this is just
14 an example of what they're doing.

15 DR. OTSUKA: Okay.

16 DR. BETANCOURT: This is just kind
17 of a real world example.

18 DR. OTSUKA: I thought I saw that
19 in your paper, too, but, you know, maybe I'm
20 mistaken.

21 DR. BETANCOURT: Yes. No, I don't
22 think we recommended that you should -- I

1 don't think that we recommended particular
2 areas. We were just -- this is just
3 highlighting what they're doing. But
4 certainly, issues around musculoskeletal when
5 you think about disability and --

6 DR. OTSUKA: Right.

7 DR. BETANCOURT: -- mortality and
8 morbidity, I'm -- we're with you on that,
9 without a doubt.

10 DR. OTSUKA: Okay. And a
11 question, you're talking about measures and
12 quality of care and quality of life,
13 functional outcomes. I think there's got to
14 be a little more focus on the patient.

15 For example, you talked about some
16 off the shelf measures. Let's just say, for
17 example, pain management. It sounds pretty
18 easy. You know, you give them morphine,
19 pain's gone, pain isn't -- Likert scale zero
20 to whatever. But Asian men metabolize
21 morphine or codeine at different rates so
22 presumably their response would be different.

1 Their requirements are different.

2 The other thing, I really impress
3 upon you to focus on the patient. I mean
4 we're here for -- this is the Quality Forum.
5 I mean if we're measuring quality we have to
6 look at the patient and the disparity or the
7 specific population we're looking at has
8 different adherence and compliance. I guess
9 compliance is the old term, but they adhere to
10 treatments differently and that'll certainly
11 affect your quality of care.

12 For example, if a kid breaks their
13 arm -- I see that a lot -- a Manhattan kid,
14 family would bring their kid in right away.
15 But if the kid was, for example, not to pick
16 on Asians but I guess I can because I'm Asian,
17 an Asian kid from Queens would have banana
18 leaves or some type of ointment placed on it,
19 and that would affect the quality of life. So
20 that brings up issues of adherence,
21 compliance, et cetera.

22 The last point I want to make is,

1 again, we're measuring outcomes and quality of
2 care. We have to -- the measures have to be
3 specific for the population. For example, I
4 try to make kids walk and sometimes if I can
5 make a kid walk 10 feet, that's the best thing
6 in the world, okay? But in the eyes of some
7 parents, if a kid never walked before and
8 they're walking 10 feet, that's great, but if
9 their foot's a little turned out or a little
10 turned in that's the worst result in the
11 world.

12 If you do a total hip in a patient
13 and they can walk more, great. But if they
14 can't sit or if they can't kneel for their
15 religious beliefs or whatever beliefs it is,
16 that's the worst result in the world.

17 So my point to you is, let's -- I
18 mean, you have all these off the shelf
19 measures that you talked about, but we have to
20 focus on the patient and there's no point
21 sitting here and measuring infection rates,
22 pain management. I think that's a waste of

1 the brain power in here and your time and my
2 time unless we really focus on the patient and
3 what the crux of the matter is.

4 And we're here because the
5 populations are diverse, you know? And
6 there's no point in measuring mortality,
7 morbidity. Let's measure quality of life and
8 what specifically we're helping with the
9 quality of life of that patient. Sorry to
10 monopolize time. Thank you.

11 CO-CHAIR ANDRULIS: Yes, on that
12 point I was -- just an add-on for further
13 discussions down the line, I was wondering
14 whether you folks had ever looked at the
15 Picker -- went to the Picker Patient-Centered
16 Care measures, you know, since there was such
17 an extensive amount of work that was done on
18 that.

19 DR. BETANCOURT: Yes, I mean on
20 slide -- so I agree with everything you've
21 said and I think that's really the area that
22 we need to push the most on. But if you look

1 at what's readily available today is the least
2 developed. So I think when we talk about off
3 the shelf it's our recommendation is moving on
4 parallel tracks.

5 My preference, I guess I'm going
6 to editorialize a bit here, I believe that we
7 need to look at the measures we have by
8 race-ethnicity that go a long way at getting
9 at patient experience because, you know, if
10 you look at HCAHPS alone, right, and you
11 stratify by race and ethnicity, we're seeing
12 some very significant differences by subgroup.

13 And my sense is that we're leaving
14 a lot of voices out there in the dark that our
15 current mechanisms of really getting at
16 patient experience, getting at some of the
17 issues you mention, are really in their
18 infancy stages.

19 Making progress in that area, and
20 this is something that we're thinking about
21 from a research standpoint, of really, you
22 know, getting at patient experience in other

1 ways, whether, you know, outside of surveys,
2 other strategies, I think, is going to be
3 critical. And I think that's something that
4 we want to highlight if we haven't highlighted
5 it enough.

6 DR OTSUKA: Yes. We obviously
7 have to use what we have. I mean there's only
8 so many outcome measures and surveys that are
9 available, but what I've done in children's
10 orthopedics is actually validate, tried to
11 validate them at least and we should at least
12 make an effort to validate it.

13 For example, well, I mean there's
14 a general survey I can give to every kid, but
15 I have -- I worked in Los Angeles and I had a
16 big Hispanic or Latino population. I actually
17 validated that study in those kids. And it
18 presumably worked out. It did work out well.

19 DR. BETANCOURT: Right.

20 DR. OTSUKA: And I feel good about
21 reporting data or -- with that outcome
22 measure, but I agree with you.

1 DR. BETANCOURT: Yes, exactly.

2 CO-CHAIR ANDRULIS: Thank you.

3 Mara?

4 MS. YOUDELMAN: So I have a couple
5 thoughts, sort of not just on the paper but in
6 a broad concept and one I just want to sort of
7 register as a little bit of a concern. And I
8 completely recognize in having worked on these
9 issues for the last, whatever, however long,
10 focusing on race, ethnicity and language
11 disparities. But I do just want to also
12 recognize that as you guys said, there's a lot
13 of other disparities based on other
14 populations.

15 And so one thing that I think
16 might be worth some discussion at some point
17 is when we are talking prospectively, how does
18 NQF look at these measures, how do we also
19 think about looking at these measures and
20 developing them for other populations?

21 And in large part and maybe this
22 is part of my disclosure that I didn't do, but

1 one of my other hats is I co-chair the
2 Leadership Conference on Civil and Human
3 Rights Healthcare Task Force. And this has
4 been a big issue for this task force of making
5 recommendations on all the different types of
6 populations that might be affected and in
7 large part because people aren't often in just
8 one population group.

9 And so I think that is just -- it
10 behooves NQF to sort of explain why the focus
11 of this project is specifically on race,
12 ethnicity and language, but also how we can
13 use what we've learned because we have come a
14 long way.

15 And it is amazing when you guys
16 said, you know, we're better off in race,
17 ethnicity and language than some of these
18 other populations and that's due to this huge
19 work by lots of people, but it's also sort of
20 frustrating that we're not there in some
21 areas, too. So I think it is just an
22 explanation and some background and then

1 looking how we can address it going forward.

2 The second piece, and I think you
3 guys addressed this to some extent, too, was
4 on language. I think that we really do have
5 to make sure the focus is on collecting both
6 language proficiency and language data.

7 And I mention this not because I
8 think this group is -- or the paper was sort
9 of lacking in it, but more because of what
10 we're seeing from policy side of things where
11 because if there's an added cost to doing it,
12 recommendations just came out from the federal
13 government to collect language proficiency but
14 not language.

15 And I can't see how you can get to
16 disparities and identify if you only have, do
17 you speak English very well, well, not well,
18 not at all. And so for the same reasons I
19 think you guys make the case we need to get
20 more granular data on race and ethnicity.

21 I think we have to make that exact
22 same case that we need that -- it shouldn't be

1 granular, but granular data on language and
2 not just a language proficiency standard as
3 we're looking at the measures.

4 And then the third piece, and
5 really this is just a comment, Joel, on your
6 issue about risk adjusting. We actually have
7 been looking at that from the policy angle and
8 trying to make that exact case that if you're
9 looking at an Accountable Care Organization or
10 medical home or something like that that there
11 should be some recognition that we do need to
12 risk adjust based on, you know, language to
13 pay for interpreters to translate materials or
14 to cover some of those other issues you
15 discussed or others, like the social
16 determinants of health, that if someone's now
17 coming into care that they might need more
18 care to catch up because of the history of
19 disparity.

20 So I think that sort of dovetails
21 nicely with what you said. It's hard to
22 create, sort of the evidence for that, but I

1 think we're trying to make that case. And to
2 the extent we can make more of that case
3 through the evidence and through some of the
4 standards that collect it to make the case
5 going forward, again, that would be a good
6 prospective way to sort of go forward.

7 DR. WEISSMAN: Yes, wouldn't it be
8 nice if ACOs that served minority and
9 disadvantaged populations were well-resourced
10 rather than always --

11 MS. YOUDELMAN: And that's exactly
12 our case. I mean a lot of it we're seeing,
13 and I think this dovetails, you know, exactly
14 with the policy developments now, and I
15 apologize. I live and breathe this policy
16 stuff.

17 But that, you know, we're testing
18 all of these new payment systems, and if we're
19 not collecting data and stratifying data by
20 race, ethnicity, language, et cetera, we're
21 going to end up with payment systems that work
22 well for the average and not for anybody else

1 and we're just going to perpetuate the
2 disparities that we've seen going forward.

3 So we're at a perfect time I think
4 exactly for this project but just need to keep
5 all of the policy pieces in mind, as much as
6 the standard-development.

7 CO-CHAIR ANDRULIS: Thank you.
8 Edward? Oh, I'm sorry. I can't see your card
9 there. I'm sorry. Thank you, Donna.

10 DR. WASHINGTON: Okay, thanks.
11 Joe and Joel, I really appreciate the
12 attention the report pays to sample size as
13 well as to some of the consequences of
14 reporting out for minority-serving
15 institutions. And so the comment I'm going to
16 make has to do with reporting out by
17 institutions that don't have a sufficient
18 sample size to stratify their population or
19 examining disparities, where they might
20 actually look good, be inappropriately labeled
21 as sort of a non-disparity-related institution
22 when in fact they don't have sufficient sample

1 size.

2 And I wonder if you might want to
3 address recommendations for reporting out when
4 the sample size isn't sufficient. I'll give
5 the example of the VA health care system.
6 They collect quality and satisfaction data on
7 a sample of patients at each site, and have
8 been publishing report cards for the past
9 three years.

10 Last year, for the first time with
11 the 2010 report, then they reported
12 satisfaction stratified by race-ethnicity for
13 every single VA facility. And what they did
14 to address the small sample size even in a
15 large -- it is the largest integrated health
16 care system in the country, and despite the
17 large samples sizes available, then only about
18 a third of VA medical centers had a sufficient
19 number of African Americans, for example, to
20 report out indicators, report out performance
21 on individual indicators.

22 And so what they did was to list

1 not applicable for the facilities that did not
2 have a sufficient sample size to avoid sort of
3 just targeting the minority-serving
4 facilities. So I wonder if you could comment
5 on recommendations or thoughts about how other
6 systems should approach that issue.

7 DR. WEISSMAN: I don't have a good
8 answer. I'll tell you that. And I think that
9 what the VA does is an acceptable approach.
10 I think saying not applicable or not having
11 sufficient sample size is not actually making
12 them look good. It's just saying that they
13 don't have the relevant populations.

14 The same thing happened in
15 Massachusetts except even to a greater extent.
16 We don't have quite as diverse a population as
17 other states in the country. And when we were
18 looking at racial and ethnic disparities in
19 hospitals about, you know, two-thirds or
20 three-quarters of our hospitals really didn't
21 have a diverse population.

22 And in that case though what

1 happened was there were still some statistics
2 that were generated that actually made them
3 eligible for incentives, which may have been
4 inappropriate. So I think that we do have to
5 pay attention to how the incentives are
6 structured and how the formulas are
7 structured.

8 And I also think that there's an
9 issue that hasn't -- that doesn't often get
10 addressed and that is, when they're -- if a
11 program is intending to reduce racial and
12 ethnic disparities, then minority-serving
13 providers that have a lot of the minority
14 populations that you're interested in, there
15 may be some programs that may be targeted
16 towards those institutions because for -- this
17 particular kind of incentive program. So that
18 if the provider doesn't have a lot of
19 minorities then they wouldn't be eligible for
20 those sorts of incentives.

21 So I think there are a number of
22 ways to go about it. I don't think any of

1 them have really been explored in great detail
2 and I'm, you know, sensitive to the issue that
3 you raise.

4 DR. BETANCOURT: I do think we
5 suggested what some organizations are doing
6 that we've seen, which is rolling up to white,
7 non-white, not optimal but, you know, that's
8 one thing, rolling up multiple years.

9 I mean at the end of the day, I'm
10 a firm believer that, you know, if you have 20
11 minorities or, you know, 90 percent, that you
12 should be able to show that everybody's
13 getting high-quality care regardless of their
14 background.

15 And so saying not applicable or
16 sample size too small, I think there are
17 things that we should be able to do that
18 really, you know, put equity at the center of
19 quality measurement regardless of that sample
20 size. So those are some of the things that
21 we've seen on it.

22 DR. WASHINGTON: Let me just add a

1 comment. Would you recommend -- so I think
2 non-applicable is actually a good solution if
3 the numbers aren't stable. But would you
4 recommend actually just publishing the
5 numbers, both the numerator as well as the
6 denominator so that people viewing the reports
7 can make their own judgment about the sample
8 size?

9 DR. WEISSMAN: I would. It looks
10 like Joe and I disagree, but I think if the
11 numbers are not -- and I think we have some
12 statisticians in the room -- if the numbers
13 are not statistically significant, I don't
14 think it's fair to the organization to report
15 the numbers. I don't think it's fair that we
16 should expect the public to make a decision on
17 the statistical stability of the number.

18 But I also agree with Joe that to
19 the extent possible, you know, maybe we're not
20 doing enough. Maybe we're saying, okay, in
21 this case we're going to clump together two or
22 three years, roll up some of the populations

1 and report the numbers in that way.

2 I feel a little uncomfortable in
3 simply reporting, you know, what if they have
4 two or three minorities and -- or what if in
5 a particular group? It can get very anecdotal
6 at that point, and I don't think it would do
7 justice in my own opinion. We don't always
8 agree on everything.

9 CO-CHAIR ANDRULIS: Thank you.

10 DR. HAVRANEK: First of all,
11 thanks for this. I thought it was really
12 thoughtful. I found it really useful, and I
13 thought it was really well done. So again,
14 thank you.

15 I had a few questions related to
16 socioeconomic position. The first is I wonder
17 if you could help us a little bit more with a
18 very operational definition of that? That I
19 think socioeconomic position is something we
20 all understand but when it comes down to
21 actually measuring it at an organizational
22 level, I think we need a little bit more help.

1 So I think you allude to income as
2 a measure of this, but I think that there are
3 some real practical problems in measuring this
4 in minority populations or using this in
5 minority populations. And I think it has a
6 lot of weaknesses. You know, a lot of
7 minority people have income that they won't
8 report to us because it's, one, it's illegal,
9 or two, it might kick them over into a co-pay
10 that they wouldn't otherwise have.

11 Second is the opposite problem
12 which is that, you know, we certainly see
13 patients who have little or no income. I'm
14 thinking of a patient I had trouble getting
15 bypass surgery for because he wasn't -- he
16 didn't have a job.

17 And he didn't have a job because
18 he'd just sold his share of his car dealership
19 and so, you know, I think income doesn't --
20 has some weaknesses. And I would love some
21 more help measuring socioeconomic position.

22 Second thing is one of the

1 problems is that disparities might not exist
2 within an organization because the disparities
3 exist at the door. So and I'm thinking of
4 large academic centers that have -- can report
5 no disparities based on race, socioeconomic
6 position, what have you, but they have, let's
7 say, 5 percent of their patients are
8 minorities or of low socioeconomic position
9 and they are situated in communities or
10 neighborhoods where 20 or 30 percent of the
11 residents of their catchment area are minority
12 patients. And that -- I wonder if you could
13 help us understand if that's a worthwhile
14 thing to measure or to deal with?

15 And then the final thing is I
16 wondered what you thought about socioeconomic
17 position itself as a basis for disparities,
18 that you kind of touch on this a little bit
19 when you talk about interaction terms, and,
20 you know, it's -- I applaud you for even
21 taking it on because it's so difficult.

22 But I'm a little bit concerned

1 that socioeconomic position may be driving
2 more of these disparities than we would like
3 to think. I'm thinking of some anecdotes of
4 patients telling me that their status as
5 having Medicaid, they felt, drove their care
6 at other institutions. In other words, you're
7 a Medicaid patient. Therefore you are X, Y
8 and Z. Therefore I'm doing this to you.

9 Or, you know, I often see
10 providers react to patients based on things
11 that are strongly related to socioeconomic
12 position. So I mean simple things, dentition
13 for instance, you hear other providers refer
14 to a patient's two or three teeth as a basis
15 for the way they're reacting to them. And so
16 I just wonder what you think and whether or
17 not that's something that this group should be
18 thinking more about? So sorry for the long
19 number of questions.

20 DR. WEISSMAN: Do you want to
21 start? Great, a lot of meat to chew on there.
22 Let me start with your second point first

1 about disparities existing at the door. I
2 think it's a very interesting point and I draw
3 back on some research I did as a graduate
4 student, believe it or not, where we were
5 looking at policies about -- what's that?
6 Yes. No, it wasn't that long ago.

7 We were looking at policies around
8 bad debt and free care, and we found that
9 hospitals in the fairly well to do communities
10 had fairly liberal policies. And the ones
11 that were in the poor communities had much
12 stricter policies. And why? That's because
13 they didn't have a lot of people coming in the
14 door that actually required bad debt and free
15 care.

16 And I think the same sort of
17 thinking could go around providers in high
18 minority and low minority populations, that we
19 do have to be a little careful about. That if
20 there's a low minority population there aren't
21 that many racial and ethnic minorities to deal
22 with.

1 They may have -- be better
2 resourced and be able to really address those
3 equity issues and come out looking pretty
4 good, whereas the provider that has, you know,
5 10 or 20 different languages to deal with and,
6 you know, a very diverse population, it can be
7 very complex and could run into a lot of
8 challenges. So I think that it's a very good
9 point. I don't know what the policy response
10 is, but I think it's something that is worth
11 thinking about.

12 As far as socioeconomic position,
13 I mean I think there are experts in this room
14 that are -- that know better than I do about
15 how to measure those things. And for example,
16 the literature doesn't even agree on the
17 terminology, you know, and socioeconomic
18 status is the one that most people are
19 familiar with. And, you know, it certainly
20 can be the basis for some disparities.

21 In terms of measurement, you know,
22 the usual things that people talk about are

1 income, education, and occupation. Those are
2 the three sort of kind of classic ways to
3 measure socioeconomic status. And I would
4 also say that you might even use some
5 ecological measures, in other words the
6 socioeconomic status of the community in which
7 the patient lives in. I think some community
8 level variables would also be important in
9 terms of identifying the socioeconomic status
10 of the patient.

11 But, you know, when I teach about
12 this, you know, it's hard to collect all that
13 data. Some of it is unreliable. Income in
14 particular has a lot of non-reporting issues,
15 and you know, probably education or even the
16 education of the parent may be the best single
17 signal that we could get, especially if you
18 think about, again, trying to use one measure
19 to address everything.

20 But I mean especially if you think
21 about what might impact a patient's use of
22 resources and the way they use resources and

1 that sort of thing I think would be a good way
2 to go. But it's -- but there's no great way
3 to do it.

4 DR. BETANCOURT: And I would just
5 add that, you know, there's no doubt that
6 socioeconomic status drives a lot of
7 disparities, but we still know that there's a
8 significant chunk that's unrelated to
9 socioeconomic status. And, you know, as Joel
10 mentioned, there's been -- David Williams has
11 written eloquently about issues related to,
12 you know, wealth and deprivation index. I
13 mean, there's 10 ways to slice this.

14 In Massachusetts from a very
15 practical standpoint, we collect highest level
16 of education as a proxy for SES and combine
17 that with insurance status to try to get some
18 sense. But even as far as I think we are
19 around monitoring and measurement, we haven't
20 begun to stratify any of that yet. We're
21 collecting it and so we're still at kind of,
22 you know, the early stages of this. So I

1 think that's going to have to be kind of a
2 best fit choice for the group.

3 DR. WEISSMAN: I did hear just
4 today that the governor of Wisconsin did not
5 go to college, so I don't know what his
6 socioeconomic status would be, but you'd have
7 to consider occupation in that case.

8 CO-CHAIR ANDRULIS: Thank you. I
9 think we have enough time to probably cover
10 all the folks who have questions or comments
11 now and that's going to be it, and then we'll
12 be on for a break. Sean?

13 DR. O'BRIEN: Well, I'd maybe just
14 pause and ask what is the plan? There's
15 question and answer now but then there's going
16 to be a series of recommendations. Will there
17 be time for discussion of each individual
18 recommendation?

19 CO-CHAIR ANDRULIS: I think
20 ultimately we're going to be looking for some
21 consensus on this, on the points and the
22 recommendations around this paper. And our

1 discussion will also be formative and bring up
2 other points that we'll consolidate. We're
3 not going to do this kind of at the end of
4 each segment, but there will be some --

5 DR. O'BRIEN: But this type of
6 discussion --

7 CO-CHAIR ANDRULIS: -- points to
8 clear.

9 DR. O'BRIEN: -- is basically the
10 plan for the day? I'm just wondering if I ask
11 a question now or don't ask a question now
12 that we're basically coming back to these
13 issues later in the day in any case? Is that
14 correct?

15 CO-CHAIR ANDRULIS: Yes. I would
16 ask it now and take advantage of the --

17 DR. O'BRIEN: Yes. Okay, well, I
18 mean, some of my questions may be a little too
19 much detail or something like that, but I
20 suppose first I would just say --

21 CO-CHAIR ANDRULIS: Well, in that
22 -- Sean, yes, in that case maybe we want to --

1 if it's granular, getting more granular detail
2 we are going to have other, many other
3 opportunities so feel free to --

4 DR. O'BRIEN: Okay. Well, then I
5 guess I just start with a couple comments or
6 questions. I really didn't learn a lot from
7 the report. I appreciated it. A lot of the
8 -- well, I guess one question, one comment I
9 would make is that there's other sources that
10 you drew from in this report that also
11 presented guidelines.

12 And I think it's probably worth
13 any places where your guidelines were
14 different from other published guidelines. I
15 looked at one that was specifically, I think,
16 published by National Center for Health
17 Statistics related to the methods used for the
18 AHRQ disparities report and it had 14
19 guidelines. And I look across and there's
20 really a lot of consistency between them and
21 your approach is very similar to theirs and is
22 a very nice delineation of the issues.

1 But there were a couple where I
2 noticed, okay, well, that the -- one person in
3 this report made a recommendation that was
4 kind of different from what you guys came up
5 with. And I could mention it or not or just
6 come back to them later, but it's probably
7 worth having some focus on why your
8 recommendation was slightly departed from
9 other approaches that were out there.

10 I think a lot of your
11 recommendations focused on reporting issues
12 and issues, one big issue is when you do
13 things two different ways and you can -- the
14 results can really depend on some subtlety of
15 how you do the analysis, whether you report
16 ratios or differences. And I think one of the
17 recommendations is, well, the only real way to
18 address that is to report things both ways
19 when they contradict one another.

20 And I think that is -- I agree
21 with that approach. But ultimately when the
22 call for measures goes out they're not really

1 focusing on well, how do we report these
2 measures? They're really saying what is the
3 measure? And they're saying basically tell us
4 a numerator and a denominator.

5 And I'm not exactly sure what for
6 something that will be submitted to NQF for
7 endorsement that's related to disparities,
8 what will that look like? Will that be
9 basically here is a measure and we say what
10 the developers are proposing is to basically
11 look at this stratified by subgroups? Or will
12 they be explicit and say we think the ratio of
13 the usage rates for this procedure across this
14 population X and this population Y?

15 If in a situation where results
16 may depend on whether you're reporting ratios
17 or differences, is there going to be a
18 separate measure that one's looking ratios and
19 one's looking at differences? Are those both
20 going into the same measure? And so I just
21 think there's some -- how some of these
22 recommendations get implemented in kind of the

1 way things are set up at NQF will take some
2 work.

3 CO-CHAIR ANDRULIS: Ellen?

4 MS. WU: So I'm hoping that, I
5 don't know, you guys or the committee or NQF
6 can do something about this issue that's
7 actually come up for many years is around the
8 CAHPS survey? And that obviously it's not a
9 perfect tool for patient satisfaction and we
10 have to get at it different ways.

11 But certainly one issue is that
12 it's only being done in English and Spanish
13 right now. And there are actually versions,
14 translated versions in other languages that
15 are not being used because it hasn't been
16 certified by NCQA.

17 So and they're looking at
18 resources, you know, they talk about resources
19 and how to do that, but it feels like fairly
20 simple. I mean, if it's a resource issue in
21 getting the translated versions certified,
22 since they're already translated, issue to

1 address to be able to -- because, you know, if
2 we take the CAHPS survey and stratify it by
3 race-ethnicity it's not going to yield very
4 much if people who don't speak English and
5 Spanish, who can't read English and Spanish
6 can't fill it out.

7 So it just feels like low-hanging
8 fruit that we can kind of get at fairly soon.
9 So I don't know if anyone can help with that?

10 DR. BETANCOURT: No. I mean I
11 couldn't agree with you more. I mean, I think
12 we're struggling with this as a hospital right
13 now because I'm, you know, I think our HCAHPS
14 is only done in English and Spanish certainly.

15 And we did actually, just as a
16 quick anecdote, we did a couple years back
17 because of our unhappiness with that we did a
18 survey, both telephone, multi-modal --
19 telephone and at point of care and the like --
20 around patient experience where we used some
21 tools like the Commonwealth Fund Minority
22 Health Survey, the Kaiser Family Foundation

1 survey on race and discrimination.

2 We created our own validated
3 survey to get our patients -- oversampling
4 minority patients. And, you know, we picked
5 up all types of things that HCAHPS never
6 picked up. And so I think, and this gets back
7 to your point as well, which is I strongly
8 feel like we need to push the boundaries there
9 and think of creative ways to get at patient
10 experience.

11 Now, we're thinking of do we need
12 to do a survey like that once every year, you
13 know, once every two years to get at these
14 voices we're leaving behind? I think it's
15 challenging from a policy standpoint because
16 I think if people's numbers look good they
17 don't want to tinker with them, right?

18 They don't want to tinker with
19 HCAHPS if everything looks nice and so what's
20 their motivation? But I do believe as
21 advocates we need to continue to push that and
22 figure out ways in which we can do the easy

1 things like translate some of these surveys.

2 But also I think it's not only
3 going to be just surveys. I think we're going
4 to need to, you know, we have patient and
5 family councils. We have -- you know, is it
6 focus groups? Is it other ways of getting
7 these voices at the table, again, things that
8 I think we should be doing in parallel.

9 DR. WEISSMAN: And I would just
10 support the idea of getting other ways of
11 collecting data for the simple reason that
12 it's not only a language issue, but it's also
13 a literacy issue where I think some of our
14 disparities occur and that it's, you know,
15 kind of who's not here raise your hand. It's
16 very difficult to assess what kind of
17 disparities occur among a population that has
18 a literacy problem.

19 DR. BURSTIN: Just one comment to
20 weigh in before we go to the next one. This
21 is exactly one of those issues that I would
22 hope that we would potentially put in a

1 parking lot for us to talk about tomorrow.

2 I think there is a real
3 opportunity potentially, for example, as the
4 NQF evaluation process to say if it's a
5 patient survey, and this is where you guys
6 would come in, is there -- if a certain
7 population rises beyond X percent of the
8 population there should be a validated survey.
9 I mean, if there's ways for us to push that
10 envelope I'd want us to return to that point,
11 but not right this second.

12 MS. CUELLAR: A couple of
13 comments, going back to the social
14 determinants, I think one of the things that's
15 very important, certainly in the southwest, is
16 lay interventionalists, for example, the
17 Promotoras de Salud and their use. And I
18 think it's a very important point.

19 Also, as Norman said earlier, as a
20 pharmacist I have to say that really looking
21 at pharmacodynamics is very important, both in
22 the Asian and the black population and in the

1 Hispanic. Someone may be diagnosed but is
2 poorly controlled.

3 Also, too, I think it's very
4 important is a first level of health seeking
5 behavior. I'm a hospital pharmacist for many,
6 many years but my brother's a community
7 pharmacist, and I actually sat and watched him
8 one day. And he did 21 patients that he sent
9 literally to the health clinic because coming
10 to the pharmacy was their first step. And
11 either taking blood pressure or whatever, he
12 was the one who intervened. And I think often
13 your community pharmacists are often not
14 looked at.

15 Also, in the language proficiency,
16 also I think really drilling down and the
17 paper you might be sending us may address
18 this, but I deal with a lot of people who
19 speak Spanish but can't read or write it. So
20 I think that's very, very important. And, you
21 know, measuring the impact of visual aids and
22 unfortunately we do not have enough visual

1 aids to help with some of those issues.

2 The other point I think is very
3 important is that lack of diversity and
4 measuring that in organizational leadership.
5 I think measuring that and how they view
6 disparities and the importance of disparities
7 in the organization is very critical, and
8 particularly now where people are looking at
9 quote indigent care versus disparities. That
10 has kind of taken the forefront. So I think
11 that's very important.

12 And also leadership, not only
13 leadership but the care providers, so I really
14 think those are all important points to
15 discuss.

16 CO-CHAIR ANDRULIS: Thank you.

17 DR. CHIN: Thanks also for a
18 fantastic paper. A question for Joel and Joe
19 and maybe also you, Helen, that there's sort
20 of another possibility that you maybe spent
21 two sentences on, but which is somewhat the
22 simple solution that finishes the work in

1 committee in half a day as opposed to a year,
2 just wanted to get your thoughts in terms of
3 why you didn't explore it further.

4 Just basically why not just use
5 all the basic measures which are being used
6 more generally for quality improvement and
7 stratifying in this case by race, ethnicity,
8 and language. You could then supplement with
9 just a few things, so, you know, there's
10 existing measures like interpreter services or
11 you mentioned paying for long bone fractures,
12 or Norman's point that there's going to be
13 sort of a research agenda in terms of more
14 disparity-specific things.

15 But the vast bulk of measures, you
16 know, probably more than 90, 95 percent would
17 currently fall in just the current measures.
18 I mean you talk about disparity sensitive, but
19 I mean they'd really be a subset of the ones
20 that already exist really.

21 And this approach, I mean, is
22 simple in terms of well, you know, you just

1 stratify by race, ethnicity, language. It's
2 flexible, so Lourdes' point about well, you
3 know, the key measures may differ depending
4 upon geographic region, population, et cetera,
5 so if you look at everything and then
6 stratifying by, you know, key variables, you
7 know, you'll capture it.

8 In any case, as Donna was saying,
9 the sample size issue is going to drastically
10 reduce whatever measures you come down to and
11 so it's not going to make that much
12 difference.

13 And then this sort of important
14 philosophical point that I think one thing we
15 do want to try to avoid doing is this issue of
16 marginalizing disparities. You know, so well,
17 you know, we do our mainline quality
18 improvement and then we have these, you know,
19 disparity measures and then we'll think about
20 disparities for these measures as opposed to
21 thinking about disparities in all of our
22 patients for, you know, everything we do in

1 quality.

2 And there's also then this sort of
3 implementation simplicity issue, and this may
4 be a question for you also, Helen, in terms
5 of, you know, the users of this, whether
6 they're policymakers or organizations or
7 something like NQF MAP that Joe is a part of
8 the steering committee for, it's a much
9 simpler argument to say, well, look, you know,
10 we have a couple principles.

11 Whatever you do stratify it by
12 race, ethnicity, language, add on these
13 additional disparity specific measures. It's
14 a much easier argument to make than us arguing
15 to, you know, a broader committee here's this
16 more complicated process in terms of finding
17 disparity sensitive measures and go through
18 this. And it's a much more involved argument
19 as opposed to two or three simple principles.

20 So why isn't sort of the simple
21 solution the way to go as opposed to something
22 that's going to be a lot more effort or, you

1 know, a lot more consultation as opposed to --
2 you'd be pretty much in the same place
3 probably. So what's the advantage?

4 DR. BETANCOURT: Marshall, I think
5 -- I mean, I'm a firm believer that -- and
6 I've been an advocate for that particular
7 position that one thing to do, and I think the
8 approach for us to not marginalize, as I say,
9 we should stratify everything by race,
10 ethnicity, and language. So I mean, I think
11 if this -- if what came out of this committee
12 was that recommendation I'd certainly be very
13 happy with that.

14 So I wouldn't recommend this over
15 that. I think that is the gold standard and
16 that's a way that moves away from this kind
17 of, well, this is the equity bucket here to,
18 you know, everything for every patient who we
19 manage in any way that there should be quality
20 and equity.

21 So this is a plan B if you will.
22 I do think that the off the shelf measures

1 which came up a bit before we do miss certain
2 things that we haven't paid attention to. I
3 think that's where we call the sentinel
4 measures might provide opportunity there.

5 But I think if this committee
6 said, "Well, stratify everything plus we need
7 to look at new areas," that for me would be a
8 very reasonable recommendation.

9 Now, certainly there's the
10 actionable, feasible lens that needs to be
11 applied, which is that's something that you
12 all need to debate. I'll just say personally,
13 I'm an incrementalist. I do believe that we
14 need to kind of crawl before we walk, before
15 we run, and I think this committee would go a
16 long way by just thinking about
17 developmentally where we could go.

18 So that might be a great
19 recommendation, the question is how actionable
20 is it? I don't know. That's something that
21 I think will require some exploration from
22 this group.

1 DR. WEISSMAN: I would also say
2 that the point you raise brings up the tension
3 between some sort of overall measure on
4 everything, on the universe, everything that
5 we collect. You know, how does everybody do
6 versus trying to look at a focused set of
7 measures? And I guess this is your challenge
8 I assume for, you know, what is the goal, the
9 end result for NQF in this exercise?

10 And so you can imagine that some
11 provider somewhere gets a score for how they
12 do on disparities or equity of care, and is
13 that based on just kind of, you know, all 700
14 measures? Or is it based on a focused set of
15 measures that people, I think, can focus on
16 and better understand.

17 And but I think eventually, you
18 know, we do certainly need to collect or to
19 stratify all the measures by race-ethnicity to
20 see what's going on. Maybe there are some
21 that are worth focusing on. I think that's
22 probably your decision.

1 DR. BURSTIN: If I could just
2 briefly respond to it as well. That's
3 actually part of the reason we've decided it
4 was time to do this project since we had this
5 old set of criteria that picked some and left
6 some on the table. And the real question, one
7 of my questions going into this is does this
8 need to be anything? It should just be
9 routine that NQF would request that all
10 measures be stratified.

11 I do think the sentinel concept is
12 intriguing because at least then you say,
13 okay, we recognize there's a universe of
14 measures out there, but we know these are
15 areas with known disparities. If nothing
16 else, publicly report these. I mean I think
17 there's some strategies there that probably do
18 get closer to the measure selection piece
19 that, you know, the Measures Application
20 Partnership is trying to think through.

21 But I'd also be curious to hear
22 Ernest's comments as you think about it. I

1 mean this was a lot of discussions about the
2 NHQR versus NHDR, just saying let's just take
3 the same quality measures and stratify them
4 rather than coming up with a different set.
5 But -- welcome by the way.

6 CO-CHAIR ANDRULIS: I'm going to
7 take the prerogative of the co-chair and
8 suggest that we just take a break. We've
9 obviously got a number of questions here. We
10 can come back to the questions after the break
11 because there are five or six more flags that
12 are up and this is going to go on for a while.
13 And Joe's raising his hand, too.

14 DR. BETANCOURT: I just wanted to
15 say Emilio, one of our co-authors is on the
16 phone. I just wanted to let people know that
17 and Emilio, I don't know if you just wanted to
18 say hello to the group? He just shot me a
19 note as well.

20 I know he's on and maybe he's on
21 mute. Okay. Well, he's on the line so just,
22 you know, he'll be on to answer questions as

1 well later with us.

2 DR. WEISSMAN: Is it possible he

3 --

4 DR. BETANCOURT: No, he's on. So
5 anyway, we can -- he'll be involved later on
6 for the Q&A.

7 DR. CORA-BRAMBLE: Joel, you had a
8 question?

9 DR. WEISSMAN: No, no, I was just
10 wondering if -- I mean if he's on can we not
11 hear him if he's trying to say something? It
12 would be great if he could just sort of chime
13 in even for two minutes? No? Emilio, are you
14 there?

15 DR. BETANCOURT: Yes, he's there.
16 He just texted me. So all right, well, we can
17 -- I mean the Q&A we can -- just he's
18 available. I just wanted to mention it.

19 CO-CHAIR ANDRULIS: Okay, before
20 we break I just wanted to have Ernie, if you
21 want to introduce yourself and just there's a
22 point of disclosure also that was requested.

1 DR. MOY: Oh, okay, got to do the
2 disclosure. Yes. I'm Ernie Moy. I'm with
3 the Agency for Healthcare Research and Quality
4 and I've been working on these various reports
5 since the very first one, and obviously
6 therefore very interested in how this all
7 turns out.

8 CO-CHAIR ANDRULIS: Okay. We're
9 on break for 10 minutes.

10 (Whereupon, the above-entitled
11 matter went off the record at 10:43 a.m., and
12 resumed at 11:08 a.m.)

13 CO-CHAIR ANDRULIS: We have a few
14 folks on the phone that haven't had an
15 opportunity to introduce themselves, and we
16 have a new committee member that's entered as
17 well.

18 So why don't we start with our
19 present committee member to introduce himself
20 to the group? And we'll also ask you for
21 disclosure.

22 DR. MCCADE: I'm Bill McCade, and

1 I was actually on the call earlier until just
2 now. But I didn't do disclosure because I
3 wasn't on early enough for that.

4 My job is Deputy Provost for
5 Research and Minority Issues at the University
6 of Chicago, and I'm a Professor of Anesthesia
7 and Critical Care there as well.

8 I'm a director for the ACGME, and
9 an officer in our State Medical Society, and
10 a member of the American Medical Association.

11 CO-CHAIR ANDRULIS: Thank you.

12 Dawn, could you introduce yourself too?

13 MS. FITZGERALD: Yes, hi, this is
14 Dawn Fitzgerald. I'm with Qsource, which is
15 a Tennessee quality improvement organization.

16 CO-CHAIR ANDRULIS: Great. And
17 Evelyn, could you also introduce yourself?

18 MS. CALVILLO: Evelyn Calvillo
19 with California State University Los Angeles.

20 CO-CHAIR ANDRULIS: And I'm sorry,
21 we're also asking for disclosures, any word on
22 disclosures from you?

1 MS. CALVILLO: I have no
2 disclosures.

3 CO-CHAIR ANDRULIS: And Dawn?

4 MS. FITZGERALD: I have no
5 disclosures.

6 CO-CHAIR ANDRULIS: Okay, is that
7 all, or am I covering everybody who's on the
8 phone? Anybody else? Okay, very good.

9 So let's pick it up with Mary, and
10 continue our conversation, discussion,
11 questions.

12 DR. MARYLAND: Thanks so much.
13 Let me first add my thank you to John and
14 Joel, very comprehensive, very thought
15 provoking.

16 I would like to ask that as we
17 look at our work over the next day and a half,
18 that we think about how to share some
19 information very specifically.

20 There's lots of talent and best
21 practices that are out there that we don't
22 know about. Some kind of way, and maybe it's

1 a parking lot issue, how we share best
2 practices and/or additional resources such as
3 language and those nuances that might come up
4 as we continue to work together.

5 I would also ask that we think
6 about beyond our work now. What impact will
7 this work have on patient outcomes, patient
8 care, the next generations of providers?

9 How do we share it so that the
10 next group in 10 or 15 years is not sitting
11 here doing this?

12 Is there a way to incorporate
13 looking at diversity, disparities in such a
14 way that rather than being an add-on which
15 always translates into more money, more work,
16 more effort, who's going to pay for it, as
17 part of what we do in the normal course of
18 providing quality health care, which I believe
19 is the ultimate goal.

20 And as long as we keep it in a
21 separate bucket, we create a divisive that I
22 believe doesn't get us where we're trying to

1 go. So I would ask that we think about how to
2 put that lens on.

3 And finally I would ask, how we
4 think about educating the future both
5 patients, how do they come to visit a
6 provider, and get the best when they leave on
7 that visit.

8 I think of the opportunity where a
9 person who did not have English as a primary
10 language needed to be referred for mental
11 health services, and then added and by the
12 way, someone who speaks Spanish. And so now,
13 what does it require to get that person to
14 that service?

15 Similarly, if you go to a
16 physician's office or provider's office as a
17 nurse practitioner, I have to add that, when
18 you come to the office for that first visit
19 someone automatically asks you about your co-
20 pay.

21 Someone should automatically ask
22 what you need to maximize your visit in that

1 facility, then we start moving the needle away
2 from thinking of only disparities.

3 CO-CHAIR ANDRULIS: One of the
4 points that you raise about disparities,
5 actually I think also has resonance broadly
6 and fundamentally with what we're about here
7 and that is, as I've had many conversations,
8 the issue of culture, while it's race ethnic
9 specific, where's the connection?

10 Everybody has culture, you know,
11 there is a cultural connection, and there is
12 a language connection to, and gradience.

13 And rather than seeing other than
14 how it fits within a broad mainstream, so that
15 also for providers organizations it becomes an
16 important consideration. So Colette?

17 DR. EDWARDS: I wanted to add my
18 accolades about the report and also piggyback
19 on what Mary has said, Marshall has said, Mara
20 and Joe, in terms of I think it would be
21 fantastic and very important for some very
22 simple things to come out of this committee.

1 From the standpoint of I want to
2 piggyback on, there was a recommendation with
3 regard to integration with NPP and MAP, that
4 I think it's really important that we not add
5 to how overwhelming this area can be, how
6 confusing it can be, add to more measures when
7 we haven't even done the basics yet.

8 And really do that integration,
9 and try to be as simple and efficient as
10 possible so that we can focus on getting some
11 things done as opposed to being caught in the
12 quagmire of the perfect measures or the
13 endless list of measures.

14 And also recognize kind of in a
15 real world perspective that it's going to need
16 to be relatively simple and something that
17 people can really act on.

18 And I think that the timing is
19 crucial with the swirling that's going on with
20 regard to medical home, and ACOs and the
21 changing reimbursement that this is a huge
22 opportunity to try to embed some of what we're

1 talking about.

2 And really embed it to Mary's
3 point, because otherwise we're retrofitting
4 after the fact with less impact, less
5 efficiency, and we just are getting to be
6 further behind.

7 DR. LU: Yes, this is Francis Lu.
8 And again I want to reiterate a great big
9 thanks for the tremendous report that you put
10 together.

11 And I just have a fairly simple
12 question perhaps and that is around the issue
13 of understanding our patient population going
14 forward.

15 I understand the focus on racial
16 and ethnic and language, there are disparities
17 related to race, ethnicity, and language in
18 what you've said in terms of where the
19 research has been.

20 But I'm just concerned that this
21 kind of focus might inadvertently lead to a
22 certain amount of generalization and

1 stereotyping, and will not give us the more
2 detailed information that we need to address
3 where the disparities might exist for specific
4 populations.

5 And I'm sure you're well aware of
6 this problem. So for example, amongst the
7 Asian Americans, you know, the median income
8 is quite high, education level is quite high
9 when you look at that generally speaking.

10 But when you look at specific
11 populations like Cambodian or Mon, that's
12 where the disparities and income issues come
13 about.

14 And I know you mentioned about how
15 to, you know, that that's an important issue
16 to think about in terms of how do we drill
17 down into those sub-ethnic groups.

18 But it seems to me that there
19 needs to be, we need to maybe strive in the
20 next day and a half to reach some consensus on
21 how to approach that issue.

22 Because I think if we don't, it's

1 going to be left to everybody doing it
2 whatever way they want, and we'll never really
3 capture that information it seems to me, if we
4 don't speak about that specifically.

5 And then one more thing is the
6 issue of capturing data in addition to race,
7 ethnicity, and language, but the other
8 measures such as age and gender and geography,
9 I think have been, you know, the AHRQ reports
10 have spoken about disparities related to those
11 cultural identity variables, let alone years
12 in U.S., sexual orientation.

13 Are things that again I wonder if
14 maybe NQF already has made decisions on this
15 that I'm not aware of.

16 But in terms collecting that kind
17 of information routinely, so that we can
18 analyze and stratify and subdivide the
19 information to get more specific information
20 that might be critically important to
21 understand the specific problems we're dealing
22 with.

1 So it's just a general comment
2 that, you know, maybe for further discussion.

3 MR. EPSTEIN: For our growing
4 perspective discussions parking lot, am I
5 correct in understanding that cultural
6 competency issues will be explored further
7 into our steering committee work? That's a
8 question.

9 Additionally, I support one of
10 Dennis's opening questions concerning health
11 literacy which has not yet been addressed.

12 Also, given that the public
13 comment period for the proposed HHS data
14 collections standards is currently taking
15 place, and especially since people with
16 disabilities are apparently going to be
17 considered first as I understand it in LGBT
18 issues, will be potentially be considered at
19 a later time. At least the LGBT work is going
20 to be more pilot as I understand it.

21 I think these are important
22 opportunities that need to be considered at

1 some time. For the present, does the mass
2 general team have any comments to offer?

3 DR. BETANCOURT: I think just
4 particularly on the last one. I mean I think
5 there's a lot of opportunity for identifying
6 and adjusting disparities in other groups and
7 I think we've touched on that.

8 I mean, I know I can comment
9 personally that we're doing a lot of work on
10 the issue of disability, but it's been a huge
11 learning curve for us.

12 You know, there's such a spectrum
13 of disability. Some people don't want to be
14 called disabled. There's a lot of knowledge
15 acquisition that I think needs to happen
16 around each one of these different issues.

17 And I think, you know, I think
18 Mara mentioned that we've come a long way and
19 I think it's because we've given it a lot of
20 attention.

21 And I don't see any of these as
22 more or less important, I just see them as

1 where we are in terms of stage of evolution of
2 knowledge.

3 It's not to say that we don't have
4 good knowledge, but my sense of it is as you
5 talk to people that we need to do more to
6 figure out what are the measures? How do we
7 ask these questions?

8 Some of the work that we've
9 already done around race ethnicity, but I
10 think that that's all, you know, should be for
11 the committee's consideration.

12 DR. MOY: Okay, great report. In
13 particular, I appreciate the flexibility I
14 think that was built into the appreciation of
15 different kind of methods. And I think
16 related to that, I was going to put two things
17 perhaps onto the parking lot.

18 One is the notion of I think it's
19 important to consider the purpose of the
20 measurement, because different methodologies
21 are probably appropriate for different
22 purposes.

1 I think in the disparities report,
2 we've kind of evolved what we think is
3 reasonable methodologies for what we do, which
4 is reporting at the national level across
5 different populations.

6 But we're often asked, well can we
7 do this for quality improvement or pay-for-
8 performance and just take this? And we'd say
9 no, don't do that.

10 So I do think that that needs to
11 be something that we consider as we discuss
12 measurement issues related to disparities.

13 And the other one is an issue that
14 we grapple with all the time, which is
15 developing methodologies for tracking
16 disparities' changes over time.

17 And I think that also is something
18 that's important because we often will see,
19 you know, larger disparities that are getting
20 smaller quickly.

21 And maybe you don't want to pay so
22 much attention to those as opposed to places

1 where there are few disparities, but they look
2 like they're starting to pop up. Just the
3 temporal trends and other methodological issue
4 to throw in there.

5 MS. TING: Oh, thank you for a
6 great report, Grace Ting. And I think I
7 really wanted to echo Mary's comment of we're
8 really trying to institutionalize.

9 And to that end I think that a lot
10 of the proposed measures that you discussed
11 and examples had identified the different root
12 causes of health disparities.

13 And so I think one of the
14 viewpoint that's missing that Leonard, you
15 know, brought up is that I would like to see
16 some discussion and potential measures
17 surrounding the systems class capability as a
18 whole. And do how many you certify
19 interpreters and translators do we have, you
20 know, throughout the country? Are people
21 regularly assessing reading level?

22 Again, I don't know that these

1 measures exist, but I think that if we're able
2 to look at the industry and the system
3 structure as a whole, we can be able to
4 identify, you know, is that some part we need
5 to address some attention in addressing the
6 clinical measures? That's one thing.

7 And then the other thing I would
8 like to encourage everyone to continue to
9 think about, is to try to select measures that
10 are going to be as cost cutting to as many
11 stakeholders as possible.

12 So from the health plan
13 perspectives, many of the ambulatory care
14 measures are really valid as well, but how we
15 get the information is really dependent on how
16 well people code in terms of diagnosis and
17 claims.

18 So what I have found in recent
19 experience through our grant project is that
20 the medical groups that we're working with
21 have a much better sense of who their patients
22 are and what clinical conditions they're

1 experiencing. But by the time we're looking
2 at the administrative data, we're much less
3 able to report accurately.

4 So if we could include that as a
5 discussion that as people across the spectrum
6 are measuring this that we can also look at
7 the linkages of how data's transmitting
8 between us and the standardization of it, I
9 think that would be very helpful. Thank you.

10 DR. CLARK: So I would like to
11 join everyone in congratulating you. I
12 thought it was a great report and really
13 enjoyed reading it.

14 The question I have beyond, you
15 know, what to measure and how to measure. I'm
16 just wondering, and maybe, you know, for the
17 MGH group and also for NQF, as part of this
18 project is there an aspect of it which would
19 be a measurement of the impact of the what to
20 measure and how to measure that will be
21 included? And that will be in some time
22 frame, that will be visible to those of us?

1 Because I think as important as
2 deciding what to measure and how to measure,
3 the bigger question is, so what will be the
4 impact of doing that on all of the issues that
5 have been discussed here early? And is that
6 nested in here somewhere?

7 DR. BURSTIN: It's actually a
8 great question. There are several ways we
9 could do that. We would certainly be able to
10 keep an eye prospectively on which measures
11 when they're submitted for maintenance, which
12 is a requirement for all measures come back to
13 NQF in three years.

14 We'd be able to see how many of
15 them, in fact, provide data if that's one of
16 your recommendations, that are stratified.
17 See if there are disparities, and as they keep
18 coming back see if there is a reduction in
19 those disparities. I think that's the first
20 point.

21 The overall impact of having NQF
22 endorse measures is a broader topic. We've got

1 an evaluation being done right now that's
2 beginning to track that. We can track it
3 because they tend to be used in federal
4 programs and things like that.

5 We don't often know, for example,
6 Grace, how many of those measures are picked
7 up in health plans, things like that.

8 But I think the more we can
9 identify which measures you guys think are the
10 sentinel measures, or just broadly how often
11 are we, in fact, getting measures stratified
12 with the results available at maintenance, I
13 think that would be a first good step. But
14 other suggestions are very welcome.

15 DR. WEISSMAN: I also just wanted
16 to comment on Grace's comment that in the
17 report I think we didn't pay as much attention
18 as perhaps we should have to system or
19 structural measures.

20 And I think particularly as
21 somebody mentioned the, you know, the idea of
22 medical homes, and that's a great example of

1 an evolving concept where some of the early
2 measures are really much more structural than
3 process or patient experience.

4 And as it's evolving and we're
5 getting we're experience with it that field is
6 moving more towards the process outcome and
7 patient experience measures.

8 And I think you could draw a
9 parallel to that with disparity sensitive
10 measures that it may be, in fact, important to
11 collect some structural characteristics of
12 provider groups.

13 You know, Dennis has an instrument
14 on this, other instruments exist about the
15 cultural competency of the organization as a
16 way to kind of start and just, almost as
17 guidelines for the organization to adhere to
18 in order to work on their disparities. So
19 that might be something worth considering.

20 DR. JACOBS: My comments will be
21 very brief. I just wanted to follow up on
22 something that Ellen said earlier, which is

1 that there may be measures for disparities
2 that actually aren't capturing disparities in
3 all populations.

4 So the example she gave of like
5 not having CAHPS and multiple languages, is
6 one way where you're looking at, it's an
7 existing measure but it's not really capturing
8 everything you can look at, so thinking more
9 about broadening your idea of there are some
10 ways in which we're not capturing disparities.

11 It may not be that there's no
12 measurement exists, but the measurement exists
13 but it's not being applied to all populations.

14 And maybe when we look at these
15 measures that there are measures out there
16 that already exist and we're going to adapt
17 them, maybe one of the processes we want to go
18 to is say well, can this measure disparities
19 for all populations that we're interested in
20 measuring disparities for?

21 Maybe we need to make
22 recommendations about how to expand them in

1 certain populations.

2 DR. HASNAIN-WYNIA: Thanks. I
3 also want to thank Joel and Joe for the report
4 which was very, very comprehensive, and all
5 the co-authors as well. I wanted to really
6 speak out in support of Collette's comments
7 regarding simplicity.

8 And I think that it's going to be
9 very important for this committee going
10 forward, to really articulate how, what the
11 work we're doing here is different than what
12 was done vis-a-vis NQF a few years ago.

13 And I think that's going to be
14 important in terms of the policy environment
15 right now, versus what it was three or four
16 years ago, five years ago.

17 So simplicity is very important
18 and I'm worried that we not come forward with
19 another, you know, 700 measures or so.

20 I think the importance of
21 disparity sensitive measures versus sentinel
22 measures, all of that I think is a very

1 important conversation to be had, but I think
2 at the end of the day we need to be thinking
3 about the end users and who is going to be
4 taking up these measures.

5 And, you know, one of my roles as
6 the lead for the Aligning Forces for Quality
7 Evaluation, which is looking at improving
8 quality in 17 markets throughout the United
9 States and equity is one of the key
10 components. This is funded by the Robert Wood
11 Johnson Foundation.

12 And I will tell you that the value
13 statement to providers around collecting race,
14 ethnicity data, language not so much, they're
15 a little bit more clear about that.

16 But the collection of race and
17 ethnicity data is one thing, but what they
18 really need information on is about the
19 utility of the data.

20 So what I'm really worried about
21 is coming up with a list of many, many more
22 measures with the end users throwing up their

1 arms saying, what are we doing?

2 Because we haven't done as you
3 said, even the simple things that many of us
4 around the table assume at this point in time
5 should be taking place. There hasn't been a
6 tidal wave of change. Let's face it, it is
7 very incremental.

8 And I think we're still crawling,
9 and we shouldn't be crawling, we should be
10 walking at least, you know, Joe, to use your
11 words.

12 So again, just to reiterate and
13 reenforce kind of thinking about what we want
14 to come out with at the end of the day and how
15 we communicate that, and how we communicate
16 how what we're doing here now differs from
17 what was done five years ago.

18 CO-CHAIR ANDRULIS: Good, great.
19 Thank you all for those wonderful comments.
20 Very thoughtful and obviously, you know, that
21 paper has been a source of great stimulation
22 for us as a committee and without a doubt. So

1 thank you again, for all your work.

2 And from here we're going to go
3 from the forest into the trees as we'll start
4 to look at pieces of your report.

5 And if you turn to your agenda,
6 you'll see that we're starting with Sections
7 3.a and 5.c, and there are questions that NQF
8 staff have put to us with regard to the
9 specific sections.

10 If you look at the, what has now
11 become the new 1045 selection criteria on,
12 should NQF focus on prevalence and quality
13 gap, as the criteria to select disparity
14 sensitive measures and assume that other more
15 general criteria are necessary for all
16 measures.

17 And then the paper recommendation
18 around known disparities that do not exist a
19 set of more specific objective criteria should
20 be applied. And then the attended questions
21 to that.

22 What I'd like to ask is if Joel

1 and Joe, and for that matter, Evelyn, could
2 kind of just give us a quick kind of recap on
3 these points. Just a few minutes of your time
4 to take us back to these sections and your
5 thinking.

6 But just to put us back in that
7 place, and then we'll begin the round of
8 issues and questions.

9 And we'll start with Marshall when
10 the time comes, and Romana. Your flag's still
11 up. We won't go to Romana. Marshall, I guess
12 will start.

13 Marshall, I just want to have them
14 start with a little synopsis. If you could
15 bring us back to those sections.

16 DR. CHIN: Just this one point
17 first that, you know, when you get very micro
18 very quickly, and I think that like Romana and
19 Collette and Grace and others raised a number
20 of really important points that are
21 fundamental in terms of the practicality and
22 simplicity issue.

1 And I still don't have a great
2 sense in terms of the overall charge and
3 purpose that we can get very micro and we need
4 to get micro eventually, but in terms of us
5 thinking about not missing the big picture,
6 I'm not sure we're there yet.

7 I was at this meeting, or
8 conference call, last Friday, it was sort of
9 a similar group looking at quality improvement
10 and reimbursement and incentives and QI.

11 And towards the end of the
12 meeting, Carolyn Clancy made this point that
13 she basically said well, details are
14 important, but guys, don't miss the big
15 picture in terms of the recommendations.

16 And I'm wondering, you know, are
17 we in danger of doing that? That we can come
18 up with some nice micro recommendations, but
19 in terms of this basic issue about the
20 practicality, usability, the practical points,
21 you know, Mary, Collette, Grace, and Romana,
22 all sort of, you know, made these points.

1 I'm not sure exactly in my mind so
2 the road map in terms of what the product is
3 that we're looking for that gets us there.

4 So in other words, the very micro
5 I guess, yes, is necessary, but I'm afraid
6 that we're not necessarily, that doesn't
7 necessarily jibe also within the big picture.

8 And so again maybe clarity from,
9 you know, Helen's had this experience, thought
10 a lot about it with AHRQ -- to the extent that
11 you're divorcing sort of measure selection
12 from then implementation, usability et al., in
13 some ways that's kind of artificial.

14 And so I'm wondering what advice
15 do you have to us in terms of thinking about
16 this issue of making sure that what we do
17 isn't just a sort of a nice stand-alone
18 product, but it's something that's going to be
19 -- it'll be used and be able to make an
20 impact?

21 DR. BURSTIN: I'll start and see
22 if Nicole or Rob or anybody else wants to add

1 anything. I think those are good points and
2 I don't want us to jump to the trees if you
3 feel like we haven't set up the principles for
4 the forest.

5 I mean, if that's important, and I
6 did hear some really good comments. I know
7 staff's taking notes, but it would be useful
8 to have a quick synopsis of what are those key
9 principles, that would be very useful.

10 I do think this committee was
11 constructed in this way quite intentionally.
12 There's a lot of end users here. There's a
13 lot of implementers here. And there's a lot
14 of smart people who've been thinking about the
15 research aspects of it.

16 So I think our hope is that by
17 bringing this group together, you would come
18 up with some recommendations that are
19 actionable. We can also make them actionable
20 in terms of our criteria.

21 One of our criteria is usability,
22 and two of our criteria are usability and

1 feasibility.

2 I think it would be useful perhaps
3 to have this committee look through, think
4 about it through the lens of the four criteria
5 that we use to evaluate all measures. To
6 think about, are there specific aspects here
7 that are especially important to consider,
8 importance to measure and report around the
9 measure gap, for example, the evidence for the
10 specific populations we've already talked
11 about, you know, how often do you have the
12 evidence, not have the evidence of known
13 disparities, came up as one of the big issues.

14 We've talked about, you know, we
15 haven't really touched very much at all on
16 sort of reliability and validity, some of the
17 issues Sean was just sort of teeing up for us
18 earlier, of the measures around scientific
19 acceptability, and then usability and
20 feasibility keep coming up.

21 But I do think it would be useful
22 to try to stay high and then dive deep when

1 you think we're ready.

2 CO-CHAIR ANDRULIS: Helen, I was
3 wondering if it might be possible perhaps to
4 describe what's happened with previous reports
5 and the way they've been used, because I'm
6 sure they ran into the same forest/tree issues
7 that we're facing, and it's a variation on a
8 theme.

9 DR. BURSTIN: Yes, it's a good
10 point. I mean, I can give you one example.
11 Palliative care, for example, several years
12 ago, really still, really very, very few
13 measures that were out there on palliative
14 care, end of life care.

15 We did some initial work,
16 developed a framework, actually Robin was
17 still around for some of this early work,
18 developed a set of palliative care practices.
19 They actually became the basis of the
20 Accreditation Standards the Joint Commission
21 uses to accredit palliative care programs.

22 We're now at the point where a lot

1 of those measures have been developed based on
2 those practices. They've just been submitted
3 to us for a palliative care endorsement
4 project.

5 So I think we tend to see that
6 sort of trajectory there of what we hope some
7 of this early thinking does. I also think --
8 and I told this example to a couple folks at
9 the break.

10 I mean, recently in our
11 Cardiovascular Committee, the chair of the
12 Committee sent back any measure that didn't
13 include the data stratified by disparities.
14 It says it's required for maintenance.

15 It's on the form. It's blank,
16 sent them back. Please send the measure back
17 when you can actually provide these data.
18 Amazingly enough, it took about a week and
19 everybody submitted their data.

20 So I do think, again, we do have a
21 role here we can play in terms of helping to
22 be that pushing force, of saying this is now

1 the new rules.

2 And I think especially, Var and I
3 were talking about this earlier, the policy
4 environment has changed so much that I think
5 there's now a whole lot more wind at our back
6 than there was five years ago when the initial
7 Disparities Committee met. But, I don't know.

8 CO-CHAIR ANDRULIS: I mean it also
9 comes back to one of the questions that was on
10 the conference call, and that is: is NQF
11 asking the right questions?

12 And this is the forum for it, you
13 know, there could be discussion around what
14 are these mega issues that might be, and this
15 larger world that might be considered in the
16 context of moving this to an agenda that would
17 be broadly applicable, or applicable to the
18 audiences that you'd want it to resonate with?

19 So I think that's fair game. I
20 think the issues around getting into the trees
21 a bit, well, I think there's going to be a
22 back and forth on it. You know, I think

1 you're going go into the trees and then the
2 forest is going to pop up again.

3 So I don't see it as necessarily,
4 now, oh, we're delving into such detail, such
5 micro that we're going to lose scope of where
6 we're headed more broadly. Instead, I think
7 it might actually inform where we go more
8 broadly, because it will probably raise
9 certain questions, elevate certain questions
10 to that level of, well, what does this mean in
11 a broader context, you know, if that makes
12 sense.

13 You look a little puzzled.

14 DR. CHIN: I guess the way I think
15 about simplistically is thinking about three
16 different areas. One is measure selection.
17 The other is creating the incentive systems so
18 they matter. And then third is designing
19 systems in a way that they lead to the right
20 things as opposed to unintended negative
21 consequences.

22 And in some way they convey, this

1 discussion about sort of measures, if it's
2 divorced from the latter two, in some ways
3 it's dangerous, because you can have great
4 measures but then terrible incentives and
5 terrible systems.

6 But some of the issues about well,
7 what makes a good measure and what makes sort
8 of a good format in the simplicity, someone's
9 having that discussion separate from the
10 implementation and the practical use, to me
11 doesn't make sense.

12 DR. EDWARDS: Does that then
13 become like the example that was given for the
14 Cardiovascular Committee, that those have to
15 be taken into account or come back to us after
16 it's done. Is that --

17 DR. CHIN: Well, see, like if the
18 paper, Joe and Joel's paper, they sort of
19 snuck this in there that, a good chunk of the
20 paper was talking about these really critical
21 implementation issues, because you have to, in
22 some ways.

1 Otherwise, it's sort of like well,
2 you know, we create measures or recommend
3 measures, and then they can be used or
4 misused, and that's where the action occurs in
5 terms of whether they either are helpful or
6 else not.

7 And so that's why to me it seems
8 still a little bit divorced. And I think it's
9 probably what, like Grace and Clint were
10 talking about as, you know, like big health
11 plans in terms of, what's going to be
12 something that's going to be, again, practically
13 useful as they're thinking about it as
14 implementers?

15 MS. TING: Right, so my experience
16 is, I really like the National Health
17 Disparities Report and I read it faithfully
18 every year.

19 But, you know, I think that, I
20 suppose, is a little too broad, and to say
21 well, how can I take these even, even the
22 state level trends and translate it in situ

1 into practice; I think that's the challenge.

2 And I think I would like to see
3 this group and the measures we select, you
4 know, definitely either bridge that or provide
5 some examples, a la NCQA, saying okay, as
6 we're accrediting you, here are some of the
7 things that will qualify for this measures.

8 It needs to be a little bit more
9 solid, I think, then these current measures.

10 CO-CHAIR ANDRULIS: Marshall, do
11 you think it's a matter of a guidance for
12 implementation that should be accompanying
13 this?

14 Like what do you do with, should
15 this move forward, the information, not that
16 they're separated from it, there's a
17 connection between the two.

18 DR. CHIN: Well, I think that's
19 what Romana was sort of hinting at with her
20 statement that we don't want to have a report
21 that's a great report that then just sits on
22 a shelf.

1 Not to say that prior reports just
2 sit on the shelf, they've really done, I
3 think, a nice job of helping push the field.

4 But as Clint says, we are in a
5 great position where it is a different
6 political environment where we can have more
7 ambitious goals, in a sense.

8 And so I think sort of think about
9 this at this time so that the product is more
10 likely to be user-friendly, and there's a
11 shorter distance between, you know, product on
12 the shelf and then actual implementation.

13 So I guess it's sort of broad, but
14 I think that probably does inform discussions.

15 For example, if the micro is such
16 that we could spend the rest of the next day
17 and a half talking about the micro and having
18 really great discussions, but at the end of
19 the day, don't have enough in terms of in the
20 linkage to the, you know, for the
21 implementation and real world practicality.

22 So I guess I'm just arguing that,

1 perhaps more so than the current agenda, that
2 needs to be just brought up to the fore by you
3 and Denise, to make sure that we do have that
4 connection.

5 So at the end of, like tomorrow,
6 we don't have necessarily just the answers to
7 these questions, but answers to these
8 questions but embed it within the context of
9 the practicality, the simplicity, the
10 usability, the implementation.

11 MS. TING: Yes. So I, well, I was
12 going to say I definitely second that in that
13 I feel that the incentive piece, and creating
14 the rightness in this, will be so critical.

15 The 45 guidelines, for example,
16 I'm pushing and pushing internally within my
17 organization, but a lot of times, you know,
18 their response is, we don't really have money.
19 So unless it's mandated, you know.

20 CO-CHAIR ANDRULIS: Mara?

21 MS. YUDELMAN: I think though,
22 that it goes back, Marshall, to your first

1 question was, is the overall recommendation of
2 this group going to be that you have to do
3 stratification for all 700 quality measures
4 that exist?

5 And if it is, that's taking us in
6 a very different direction than if we're
7 saying, we're looking for specific measures
8 that are addressing disparities.

9 And so I wonder if that's almost
10 like the global question that we have to start
11 with is, you know, and to some degree it is
12 simplistic. Because, you know, you just have
13 to do this for every single quality measure
14 that's out there.

15 And then we have to figure out
16 what that actually means, and then we go into
17 the weeds a little bit. But, I mean, we were
18 talking, Helen and Romana at the break, are we
19 at that point where we can do that?

20 And I think, yes. I mean, I think
21 we've got enough of the basis in the law, and
22 the policy, and in the backbone of NQF, and

1 what you said with the cardiovascular folks
2 of, you know, if you say it has to happen,
3 they're going to find a way to have to happen.

4 So is that sort of that
5 preliminary discussion that we have to have?
6 Are we really talking about, this is going to
7 become universal, that's our recommendation,
8 and now we're giving you the road map how to
9 do it?

10 Or are we really putting out a
11 call for specific measures and just sort of
12 taking that little pieces, here we go from
13 what we did five years ago?

14 CO-CHAIR ANDRULIS: Sean?

15 DR. O'BRIEN: Yes. I was going to
16 throw out just one tentative idea for ways to
17 narrow and focus the scope of the steering
18 committee.

19 I mean, it's probably important to
20 think about broadening the scope at the same
21 time, but in my mind I think you can
22 distinguish this looking at population level

1 disparities or the folks as looking across
2 geographic areas and across time, and just
3 kind of looking to identify potential
4 disparities.

5 That's a little bit different from
6 looking across providers and different other
7 levels, other units of health care providers
8 where there may be raising more issues related
9 to attribution.

10 That it seems like that would be a
11 more specific area where you could actually do
12 something that's different from what other
13 groups are doing to basically what issues
14 arise and how and we're actually not just
15 looking at measuring disparities, but actually
16 comparing across units.

17 And sample size issues that people
18 have mentioned are going to be, you know,
19 really come into focus.

20 Issues of case mix adjustment and
21 stratification, those issues are going to come
22 into focus, because all the issues of

1 interpretation and attribution are really
2 going to be brought into play there in a way
3 they wouldn't if you were just doing a
4 population-level focus. And I think there'll
5 be plenty of areas to actually make
6 recommendations.

7 MS. MCELVEEN: Two things. First,
8 you've obviously given us a lot to think about
9 and consider. And so we were first reviewing
10 the paper to see how much of the paper
11 addresses the issues that you've raised.

12 Secondly, my other question was,
13 do you feel that, as a group, that you really
14 are looking to make recommendations more on a
15 system and structure level?

16 And then based on those
17 recommendations, talk about how the measures
18 would be addressed?

19 So, in other words, providing
20 recommendations on how a system, or broader
21 recommendations on how the system should be
22 set up, or how it should look for implementing

1 the measures properly. Is that kind of the
2 sense of what the group is saying or -- does
3 that make sense?

4 CO-CHAIR ANDRULIS: Go ahead,
5 Romana.

6 DR. HASNAIN-WYNIA: I think that's
7 one approach. I do think that -- you know,
8 I'm in fear of contradicting myself.

9 So I'll use Mara's example of, so
10 if we're thinking about, you know, kind of
11 focusing on the systems level, I think that
12 that would be good on the one hand.

13 But it shouldn't be at the expense
14 of completely not having a conversation about
15 a measure that should be, you know, at least
16 discussed and voted on, vetted through this
17 committee.

18 So, you know, currently as Mara
19 pointed out in the new regs, we have English
20 proficiency but nothing about language spoken.

21 So it's really hard to kind of,
22 from a system perspective, target the

1 resources needed to address disparities based
2 on language if we only have proficiency
3 information.

4 So I think that, you know, one
5 goal of this committee could be to address
6 that gap in the current regs through the
7 measures that we discuss.

8 So, you know, that's an example.
9 So I do think we need to strike a balance, and
10 I also kind of share Marshall's, I don't know
11 if it's a concern or just his point, that I
12 think a little bit more guidance in terms of
13 how we proceed would, I think, benefit the
14 entire committee in terms of making the best
15 of our time around a larger framing, around,
16 you know, where are we going to spend the next
17 two hours.

18 And before we really, you know, do
19 we need to really dig down into the weeds
20 right now or do we need to have that framing
21 discussion right now?

22 And make that a very explicit

1 goal. And I'm not quite sure what the process
2 is, Helen, and maybe you can speak to that,
3 but maybe that's something that the committee
4 needs to come to an agreement upon before we
5 actually do get into the weeds.

6 CO-CHAIR ANDRULIS: Okay. Well,
7 it seems to me there are kind of two, putting
8 it simplistically, two paths going here.

9 One is around, almost sounds like
10 you're talking about guidance for the group
11 for the next period regarding the work ahead
12 of us.

13 But also coming back to this
14 guidance of what this means for the field, you
15 know, and how you help them, so it's almost a
16 two-part.

17 But I think, you know, correct me
18 if I'm wrong, Marshall, but it seems like
19 there are three levels that we're talking
20 about in terms of addressing these measures.

21 One is kind of a level of sentinel
22 measures or other measures. The other one,

1 the 700 measures.

2 The third is application of more
3 broadly, coming back to the cardiovascular
4 example of, well, it doesn't matter, it should
5 be considered in whatever your view, you know,
6 beyond the 700 measures.

7 And so, I think a point of
8 consideration both for NQF and the group is:
9 well, which way are we going on this? Are we
10 looking to apply a broad-based, broadly
11 applicable approach or are we saying well,
12 let's go with, you know, go with something
13 that's --

14 DR. CHIN: Well, there's also
15 maybe a practical answer to that, so if you
16 start with the 700 because of the sample size
17 issues that Sean, and I think Donna, had
18 raised originally, you rapidly come down to
19 the very small number anyway.

20 So in practice, you're dealing
21 with a very small number anyway. But there
22 are the existing measures, the measures that

1 exist that are really disparity-specific in
2 terms of, you know, ACE inhibitors,
3 interpreter services, you can say, well, you
4 know, that's a very disparity-specific measure
5 that exists right now.

6 And then you have, you know, the
7 field of, well, disparity measures that we
8 want to have, but they don't exist now that we
9 need to find. So, I mean, that's what it
10 comes out to practically.

11 You know, a small set of the 700,
12 which, you know, I guess it's going to be
13 determined by the sample size alone. The
14 things that we all know in terms of disparity
15 specific things.

16 And then the ideal, that, you
17 know, we need to have a call for proposals for
18 in terms of developing important measures that
19 don't exist now.

20 DR. BURSTIN: I guess my sense of
21 it is, we were going to actually do all three.
22 And I don't see of us doing one or the other.

1 I think there's, you know, I think
2 we very much want to have a sense, and if you
3 look through these questions they get kind of
4 deep, but they're also pretty broad.

5 Should we just say, you know, one
6 of the requirements could be, based on sample
7 size, can you provide stratified data by
8 three-year maintenance? It could be as simple
9 as saying, yes, on all measures. That's part
10 of the determination we'd like to hear from
11 you.

12 But I think, you know, one
13 question might be as we go through this, maybe
14 as we work through each of these issues we
15 could talk about sort of the inside the
16 measurement space, how it applies, and maybe
17 a little bit about sort of outside the
18 measurement space, the implementation, the
19 implications of doing X and what needs to
20 happen.

21 That might be one way to do it,
22 but I think our hope very much is you're going

1 to help us write this call for measures on the
2 cross-cutting measures.

3 And so as we're going through this
4 process, we hope you'll come up with what we
5 hope are the measurement concepts that we are
6 going to want to bring in, what are that, what
7 is, what are, what is that small set of cross-
8 cutting measures that you think would really
9 add value?

10 Because currently we really have
11 almost none within the portfolio. And the
12 question is, what would be useful out there?

13 And we've heard, certainly, that
14 there's great interest in picking up some of
15 those measures if they existed, in terms of
16 picking them up from limitation.

17 CO-CHAIR ANDRULIS: Okay, so would
18 you like to proceed?

19 MS. NISHIMI: So, let me just try
20 and reflect on what I heard here, and recap on
21 how we might proceed, really teeing off of
22 what Helen just said, and see if that's

1 amenable to the group.

2 I heard that there is a desire to
3 look at some big picture issues first, some of
4 the system's approaches, you know, the general
5 direction the committee thinks perhaps
6 implementation should take and the like.

7 There's also the notion though
8 that drilling down to some of these questions,
9 which is what Helen just proposed, perhaps
10 should be looked at through the different
11 lenses so that we look at these questions now
12 as they've been laid out in this agenda,
13 section by section.

14 And we first discussed what the
15 committee's thoughts are about the big
16 picture, any implementation concerns
17 surrounding that and the like there. And then
18 we perhaps narrow it down to specific
19 applications.

20 So when you're talking about
21 population level reporting, when you're
22 talking about sentinel, and by population

1 reporting I'm referring to the existing NQF
2 population of metrics, I'm sorry, mixed things
3 up, you know, inappropriate use of the word
4 population there. That we look at in terms of
5 the notion of sentinel measures and that we
6 look at it in terms of where we would like
7 things to go.

8 So that we systematically look at
9 these questions but through two different
10 lens. And that will then allow us to march
11 through the different sections rather than
12 have sort of a large free floating thing up in
13 front.

14 And then frankly my concerns will
15 be we will then start repeating ourselves when
16 we got to the questions again. So does that
17 approach seem fair?

18 Yes, thanks Helen. Then why don't
19 we just proceed that way, Dennis?

20 CO-CHAIR ANDRULIS: So would it be
21 okay, Joe, Joel, if you could take us back to
22 these sections and just give us a little just

1 brief review?

2 DR. WEISSMAN: Sure. I mean just
3 the next slide I think would be enough,
4 because you already know about this one. Oh,
5 sorry, the one after this, yes.

6 We were also trying to think
7 operationally about what the charge of the
8 group was, and we were trying to think of the
9 different measures in different buckets.

10 And so we kind of thought of the
11 measures that currently exist. And I think in
12 previous conversations there are some measures
13 that are already stratified by race and
14 ethnicity, and there either are or are not
15 disparities evident in those.

16 And, you know, at least our
17 suggestion that the, at the outset was to take
18 those as disparity measures.

19 Now I think in light of some of
20 the conversation about whether or not there
21 should be a relatively focus group or whether
22 you should go through everything, is something

1 that you all are probably going to have to
2 decide.

3 But then I think the other
4 criteria that we mentioned that are worth
5 considering are, there may be some focused
6 measures that have clear evidence of
7 disparities that you really want to put in as
8 a, basically to profile an organization.

9 But then we should think about
10 other kinds of scenarios, other situations
11 where, that are worth exploring and that we
12 may not be looking at, at this point.

13 And these other criteria come into
14 play, you know, high degree of discretion,
15 and I would put in kind of evolving
16 technologies.

17 I mean, you know, I think the
18 literature is replete with examples of
19 disparities of evolving technologies where
20 there's a lot of discretion.

21 Some of the early work that I did
22 with Arnie Epstein on coronary artery bypass

1 graft and PCI is a good example of that.

2 Communication sensitive services
3 is we're finding more and more that those are
4 the ones that persist as having disparities
5 and so on.

6 So this is just a way of, you
7 know, we can't answer how big a bread box to
8 look at, but if you wanted to kind of think
9 about the measures as being in different
10 buckets with and without evidence of
11 disparities, with or without measures
12 stratified by race and ethnicity, and then
13 where to look for other measures that might
14 not be there especially as you entertain
15 measure development recommendations that
16 might, these might be helpful to look and
17 think about.

18 Joe, you want to add anything?

19 MS. NISHIMI: Okay. So in terms
20 of some of the global questions I heard the
21 committee raise around this section, what I
22 heard was, create simplicity about what should

1 be measured. And one of the solutions offered
2 was to just require everything be, you know,
3 looked at in the portfolio by race and
4 ethnicity.

5 So that this notion of a subset if
6 you will, of disparity sensitive measures has
7 been overtaken by events, OBE, as we used to
8 say at VA.

9 And so I think that's one of the
10 big picture recommendations that the
11 committee, you know, should opine on and it
12 will be very helpful.

13 I mean as I think Marshall or
14 someone said, you know, maybe we could get rid
15 of part of our agenda in one fell swoop by
16 just saying, you know, yes, we don't need to
17 apply all these existing criteria. So some
18 discussion for the staff will be useful.

19 DR. O'BRIEN: Well, this isn't
20 exactly following up on that comment because
21 I'm just looking at the slide.

22 And what I see there, the one

1 point that's up there that I feel is the most
2 like problematic, not problematic in a bad
3 way, but in terms of having issues surrounding
4 it, is the recommendation to focus on outcomes
5 rather than process measures.

6 I see those as obviously valuable,
7 but they're the most, the ones that bring in
8 the most issues related to risk adjustment.
9 And I feel like there's probably, everyone in
10 the room has different ideas about the issue
11 of risk adjustment.

12 I just feel like it's a, so if we
13 come up with a recommendation that yes, we
14 think we should be in the area of disparities,
15 we need to be focusing more on outcomes, have
16 we really thought that one through or not?

17 When I've been on NQF activities
18 at some of these outcomes where the issues of
19 attribution are unclear that lead to the most
20 debate and protracted discussion and like
21 uncertainty about what the measure's trying to
22 do.

1 DR. WEISSMAN: I have just one
2 quick comment on that, and that is that I
3 think that the issue with outcomes often comes
4 back to the accountability and responsibility
5 issue about, is a provider accountable or
6 responsible for outcomes once the patient
7 leaves their door?

8 And I think that discussion is
9 evolving. And a great example of that is
10 hospital readmissions where, you know,
11 hospitals have said in the past, we're not
12 responsible for readmissions.

13 Well, I think the world is
14 changing. And that there is a certain
15 responsibility.

16 We haven't figured out exactly how
17 that's going to be accomplished, but there is
18 a certain responsibility to reach out in the
19 community, to engage the patient in ways that
20 reduce those sorts of adverse outcomes.

21 So I agree with you, and at the
22 same time I think that we have to, I at least

1 see an evolving discussion around those
2 issues.

3 DR. BETANCOURT: And I would just
4 add too, I mean we tried to, I think for some
5 this works better than for others.

6 So we gave the example of flu
7 shot, right? So you could look at flu shot by
8 race and ethnicity and see no disparities in
9 offering a flu shot to the patient. But then
10 you look at actual receipt of a flu shot by a
11 patient, patient getting the flu shot.

12 And unless you identify, you know,
13 people can very easily check the box,
14 mammogram offered, I mean this is the major
15 kind of hub of the work around cultural
16 competency, is that we can say, yes, I offered
17 this but the patient refused. That's the very
18 easy way out.

19 If you don't look at the receipt
20 of services, you'll never know that there's a
21 problem and you won't figure out ways to solve
22 it, I believe.

1 So I think for some there's risk
2 adjustment required, they're more complex.
3 For others, I think they become ways for us to
4 identify areas for innovation, for more work,
5 for interpreters, for language, and for
6 information in a low level health literacy,
7 for assuring that an interpreter is present.

8 I think there's other systematic
9 things you could learn about that. So there's
10 probably several of them. We give as an
11 example, flu shot, that lends itself well to
12 outcome measurement as a way of driving
13 improvement.

14 And I think we've done that around
15 diabetes, where we just took some very big
16 slices.

17 We didn't get caught up in who's
18 attribution it was, we just know that we need
19 to better with like, you know, diabetics,
20 because we're doing less well for them.

21 Now then you start to experiment
22 and figure out what you need to do and it runs

1 the gamut between public health issues and
2 medication inherent, so that's my perspective
3 on it.

4 DR. BURSTIN: I'll just make one
5 comment, that NQF already updated our
6 evaluation criteria this past year, did a
7 whole task force on evidence guidance and
8 specifically recommended only measures that
9 are outcomes or a process measure so they
10 clear a link to outcomes.

11 And so we've already said, distal
12 measures too far from the outcome, won't get
13 through regardless of whether it's disparities
14 or not.

15 So I think one caution for us
16 going forward is I don't think we need to
17 spend a whole lot of time on issues, that is
18 sort of across all measures. A good measure
19 is a good measure regardless of the purpose.
20 We wouldn't want a measure that's so distal
21 process wise. But it's a good point.

22 CO-CHAIR ANDRULIS: And our work

1 on looking at organizations, what they were
2 doing process structure wise, that's the same
3 question that came up over and over again, how
4 can you link this to outcomes?

5 If we have the presence of X, you
6 know, a procedure of some sort, what does it
7 mean in the context of outcomes?

8 And that was what was missing,
9 organizations were looking at it only from the
10 presence of the process or the structure, not
11 looking at it as the link to outcome.

12 And so we'll move over to
13 Elizabeth and then Romana.

14 DR. JACOBS: We've been having a
15 discussion here so you'll probably hear both
16 our thoughts in this conversation.

17 So we were just wondering about
18 the 700 measures that are already out there.
19 Would it be worthwhile then to think about
20 which of those would be disparity sensitive
21 measures? I mean I think that's what you
22 proposed.

1 But one of the ways in thinking
2 about making this simplistic is making sure
3 that we're not asking people, sometimes it's
4 really hard as we talk about sample size
5 issues and language issues as sometimes it's
6 hard to stratify across all those measures.

7 And do we want to simplify it by
8 actually making it easier on people, in
9 addition to saying well, of those 700 measures
10 maybe there are 10 or 20 that aren't captured
11 there that we think are really important.

12 So I do think that there is, I
13 agree with the simplicity, but I also don't
14 want to miss important things that would be
15 important to look at if we don't think outside
16 those 700 measures. So I'll just stop.

17 DR. HASNAIN-WYNIA: I actually
18 have a direct question, and if I missed this
19 in the report and it was there, I'm sorry.

20 But of the 700 measures, so this
21 is on page 19 of the report, of the 700
22 measures of quality of care for both

1 ambulatory and institution based, of those 700
2 how many in the last disparity specific
3 committee were endorsed as disparity
4 sensitive?

5 MS. MCELVEEN: Thirty-five.

6 DR. HASNAIN-WYNIA: Thirty-five?

7 DR. WEISSMAN: They were just
8 ambulatory though, right?

9 DR. HASNAIN-WYNIA: They were just
10 ambulatory though, right.

11 DR. YOUDELMAN: How many
12 ambulatory, and what percentage is disparity
13 sensitive?

14 DR. BURSTIN: Sort of a point at
15 time estimate, which is why we wanted to
16 revisit this. It's about four years ago, my
17 guess is it probably at about 150 or 200, but
18 just a guesstimate, but again, there's many
19 more measures now.

20 DR. HASNAIN-WYNIA: So I also just
21 wanted clarity in terms of the question that
22 Robyn posed, which is, you know, one of the

1 most simple things that we could do is say,
2 and I don't know if I'm interpreting the
3 recommendation correctly or, you know, what
4 we're supposed to deliberate.

5 But one recommendation being that
6 we just say across all the 700 measures, we
7 put a recommendation out there that says that
8 we stratified. Period. So that's one.

9 Then the second layer is, that we
10 want to make sure that we're not missing
11 sentinel disparities measures that we, you
12 know, that we absolutely should be focusing
13 on, which we to date have not, basically
14 brought to the table.

15 So that those are the two, I mean
16 I'm very much oversimplifying right now, but
17 those are kind of the two broad strokes that
18 we're contemplating.

19 And then Liz offered a little bit
20 more nuance in terms of going back to the 700,
21 and we talked about the 35 or so ambulatory
22 disparities sensitive measures.

1 We don't have inpatient, but Joel
2 for example, just, you know, brought up the
3 example of the readmission measure which is a
4 really important one.

5 It's very timely. I mean there's
6 a clear policy link to it. There's an
7 incentive, I mean there's or a disincentive,
8 or however you want to look at it.

9 So I guess what I'm asking for is
10 clarity of the question, and did I frame what
11 Robyn was asking us to contemplate,
12 accurately?

13 MS. NISHIMI: From my perspective,
14 yes.

15 CO-CHAIR ANDRULIS: Yes, getting
16 back to the larger picture versus the detail.
17 One of the I think attendant questions is,
18 could you use some subset, sentinel
19 indicators, or another group for guidance?

20 You know, these are more concrete,
21 recognized measures that are more broadly
22 accepted or understood.

1 And perhaps a charge that could be
2 put on the table is, could you then build an
3 agenda around making sure that there is a
4 practical application that would then
5 resonate, again come back to the field?

6 And field say, okay, now I
7 understand how to use this, what importance it
8 has, and perhaps how it has broader effect in
9 terms of other measures.

10 DR. BETANCOURT: I just wanted to
11 comment on this 700, you know, look at them
12 all or not. Of course, I can't come up with
13 a good example now, but I remember as we
14 started to go through them there were some
15 that just when you look at them, you just said
16 this doesn't really have, and I don't have a
17 good example, but I remember multiple saying,
18 yes this, there's no there there.

19 But it may be worth maybe at some
20 point for the committee to get a snapshot of
21 some of these. We don't have them accessible
22 here.

1 Because you might be able to more
2 clearly see whether, you know, which path is
3 worth going at, because you might say, well
4 these, I also think the actionable, feasible
5 lens is worth thinking about as well as you
6 mentioned.

7 CO-CHAIR ANDRULIS: Mara and then
8 Romana, you're back on. No, Romana.

9 MS. YOUDELMAN: I guess another
10 way of looking at this is instead of an opt-
11 in, which is sort of the framework you've put,
12 do we do an opt-out?

13 And I mean I'm sort of going back
14 as an advocate, and I don't know the
15 practicalities of how this works in the field,
16 so, you know, I leave it to the rest of you
17 for that reality check.

18 But maybe what we're really
19 thinking of is we want to include as many as
20 possible. And so we should be starting with
21 that threshold of yes, all 700 should be in.

22 But maybe there is some subset.

1 And maybe it's, you know, I don't know how
2 many, but that shouldn't be in for whatever
3 rationale, but there's a really good rationale
4 for why they shouldn't be in as opposed to
5 trying to find ways to get, you know, put them
6 in the bucket. It's really how do we take
7 them out of the bucket.

8 And I think the basis for that at
9 least in my thinking is probably based on, I'd
10 rather push as far as we can go. We're at a
11 good crossroads.

12 Too, what I hate about existing
13 disparities research is it always seems to be
14 focused on the same darn conditions because
15 the standards and the basis is there, so we
16 keep getting that data over and over again,
17 and we don't really have, you know, we really
18 don't it expanding as much I'd like it to.

19 And so I guess that's just
20 possibly a different way of thinking of it.
21 Is there any way to do it as, we all are in
22 until there's a really good rationale for

1 taking them out?

2 CO-CHAIR ANDRULIS: Collette?

3 DR. EDWARDS: So I think kind of
4 big picture, looking at all 700 is very
5 appealing but from a practical standpoint it
6 just is, just thinking about it and not even
7 having to do it is overwhelming.

8 And looking at it from the health
9 plan perspective and also looking at it from
10 the hospital perspective, physician in the
11 office perspective, it's just not going to
12 work.

13 So I think having it out there as
14 the goal, but then having either something
15 staged that has some rationality with some
16 statement of, we recognize ideally it should
17 be 700, but we also recognize that it's not
18 going to happen. And therefore, we've come to
19 this subset and here's the reason.

20 And the four in that second
21 bullet, the four sub-bullets are very
22 appealing from the standpoint of, I think

1 they're very actionable, kind of one-on-one at
2 the practitioner level, they resonate at the
3 health plan level. And they're also tied to
4 what's going on related to consumers, as well
5 as medical home, ACOs.

6 It just really lines up with a lot
7 of things that are kind of converging right
8 now. So does that become a set of filters for
9 some subset of the measures?

10 CO-CHAIR ANDRULIS: The guy whose
11 tent fell over, Marshall.

12 DR. CHIN: This is much for Helen
13 again in terms of, so in practice I don't
14 think anyone's going to be doing 700 measures.
15 And so there are other NQF initiatives like
16 MAP where they're going to try to come up with
17 a subset, which I'm gathering is going to be
18 more than what are like 40-100.

19 So again, a system of discussion
20 is already happening so that in so much as
21 moot, that, you know, no one is going to say,
22 well, do all 700. But there are wider

1 umbrella NQF initiatives that is already
2 cutting it down for us in terms of for the
3 general population.

4 So it gets back to Romana's point
5 that, in some ways it may be we're saying
6 well, do race, ethnicity and language on
7 whatever generic subset are going to be done,
8 but then don't forget about these disparity,
9 sentinel or disparity specific things, which
10 you haven't included but, you know, we as a
11 committee think we have added value in terms
12 of saying you should do these also.

13 DR. BURSTIN: What Marshall's
14 referring to is that there is another effort
15 in NQF now called the Measures Application
16 Partnership, which is trying to at least make
17 recommendations on the selection of measures
18 for various pay-for-performance and/or public
19 reporting programs.

20 They're struggling right now
21 trying to figure out exactly what those
22 criteria are. We've been working with them to

1 think that through.

2 And I don't think any of us are
3 saying, therefore the result of this committee
4 is to stratify all 700. I'm trying to think
5 about more principles going forward. So as
6 measures come back up to us for maintenance,
7 you know, the principle is you must always
8 just stay strong.

9 Every measure that comes back to
10 NQF for maintenance must have data on the
11 measures in use and the available date on
12 disparities.

13 And then potentially you follow
14 something like this to say, if you're going to
15 publicly report or use these measures for pay-
16 for-performance, you would want to stratify
17 them.

18 I mean NQF endorsed measures
19 aren't endorsed just for the purpose of QI.
20 You can use any measure you want for QI, but
21 if somebody's going to pull up a measure and
22 use it, select it for payment in a renal

1 bundle payment program or use it for payment
2 in a hospital program then boy, based on the
3 data we've seen, this is one that should be
4 considered stratified before you do your
5 payment, things like that.

6 I think it takes it to a different
7 level. I don't necessarily want this
8 committee to just say, blanket all 700
9 disparity sensitive, I think that would feel
10 sort of false and incredibly impractical.

11 DR. CHIN: I think it's a critical
12 issue because here's where the lever is, I
13 mean money. And so we're talking like either
14 actual pay-for-performance, reimbursement or
15 else public reporting, that's where there's
16 power.

17 So that's where we really need to
18 be careful in terms of making sure we get it
19 right, terms of recommendations on the
20 disparity measures because that's where it's
21 going to have an impact.

22 DR. BURSTIN: Currently there's no

1 requirement that have the measures that CMS or
2 others pick up for payment, that they stratify
3 or look at any of that. And I think the
4 timing is right, given the fact that those
5 data are now increasingly available.

6 That could be a pretty important
7 lever that we've never had before, which I
8 think was part of the idea of bringing this to
9 you again five years later.

10 MS. YOUDELMAN: I agree. I mean I
11 wasn't expecting there to be like a trigger
12 date, and all of a sudden on X date you have
13 to, you know, do it.

14 I do like the idea of, you know,
15 as things come up for review, and I guess I
16 would also suggest, is it practical to say as
17 a new standard is coming through, you need to
18 evaluate whether you can do it from the get-
19 go.

20 Because at least in other data
21 collection it's easier to do it from the get-
22 go, rather than go back a couple years later

1 and fix it. So that might be another
2 principle, is one, as existing standards are
3 coming up for renewal, what's the lens on
4 which they are evaluated?

5 And then two, as a new standard is
6 being developed, can you make sure that you're
7 developing it in such a way that you are
8 addressing the disparities issues?

9 CO-CHAIR ANDRULIS: Yes, and
10 Collette, coming back to your point. It
11 doesn't necessarily preclude using those four
12 points there as guidance for health plans or
13 others, it's just we're thinking a broader
14 scheme. But in terms of interpretation and
15 guidance for application, then that could
16 easily apply.

17 Norman?

18 DR. OTSUKA: I'd like to say that
19 orthopedic surgeons, or our society has been
20 at the forefront in diversity, but I must say
21 that I disagree with you, Helen.

22 I don't think the wind is

1 necessarily behind our sails, at least for
2 orthopedic surgeons.

3 Because we do a needs assessment
4 and we did one, I forget, five or eight years
5 ago, and culturally competent care was low,
6 reimbursement, you know, other advocate issues
7 were high up.

8 And we redid that needs assessment
9 recently, two or three years ago, and still
10 culturally competent care, although we set up
11 a diversity board and have done teaching, have
12 done education, marketing.

13 So my point to you is that, I mean
14 I don't want to keep the measures too plain
15 or, I mean I agree with simplicity but they
16 have to be good, you know, garbage data in,
17 garbage data out.

18 So maybe one of the motives of our
19 measures would be to raise awareness of
20 culturally competent care and health care
21 disparities amongst our grass roots surgeons
22 and physicians. And I think that would be

1 another motive for some measures that we do.

2 MS. NISHIMI: Well, I will say
3 that I still haven't heard clarity yet on
4 which way the committee feels. And so I don't
5 know if you want to literally run the table or
6 not. I just, I don't think that we have clear
7 guidance on how to handle this.

8 Or if we don't want all 723 in
9 there, what are our specific exclusionary
10 criteria if you will going to be? Are we
11 going to go with these four, some other add on
12 to this four or something? I think we just
13 need to be a little bit more crisp.

14 CO-CHAIR ANDRULIS: You know, I
15 think, again I open it up to the table too,
16 but my interpretation is we're talking about,
17 do we come up with something that's more, as
18 I said more broadly applicable?

19 Or do we select out certain subset
20 and use that as a starting point for
21 organizations, for plans that would recognize
22 these as indicators that, okay, we know these,

1 we can use these to build on for guidance?

2 I feel, I mean I think the
3 question on the table is, do we want to go
4 broadly, or do we want to go more narrowly?
5 Or do we want to do some hybrid of some sort
6 that would provide the potential to consider,
7 and parameters for considering other measures
8 while you set up a design that considers
9 specific measures to begin with? Does that
10 capture it, Robyn?

11 MS. NISHIMI: Yes, I think that
12 gets most of it.

13 CO-CHAIR ANDRULIS: Luther?

14 DR. CLARK: Yes, I think I agree
15 with what you just said. My sort of position
16 listening to this is that we'd want to be more
17 inclusive.

18 And while 700 measures are a lot
19 of measures, I mean there are 700 measures.
20 So that there should be a reason not to
21 include them rather than looking for reasons
22 to include them.

1 But at the same time, it's
2 important to really, you know, highlight those
3 that are particularly important or valuable.

4 So I think we can do both so that
5 whoever created the 700 measures, there are
6 the 700, so you don't want to give automatic
7 outs, but realizing that it's not going to be
8 valuable for all of these.

9 And I was thinking in terms of the
10 potential maybe to even detect disparities as
11 to where they might not be apparent. And
12 along those lines, I wanted a clarification.
13 I wanted a point in the slide.

14 So the, when you speak to data
15 exists and show no disparities, is that data,
16 it does not show disparities or it shows that
17 there are no disparities?

18 DR. WEISSMAN: No data exists on
19 disparities, is that that statement?

20 DR. CLARK: Yes, but that's, I'm
21 saying that you may not show disparities that
22 exist because they weren't detected.

1 DR. WEISSMAN: Right.

2 DR. CLARK: And that's where, you
3 know, my sort of tilt for being more
4 inclusive, because it is possible that you,
5 there's no reason to suspect or think there
6 are disparities but, in fact, they do exist
7 for reasons that may not be apparent.

8 DR. WEISSMAN: Yes, I think you
9 can go a little, and we were driven a little
10 crazy about thinking of all the different
11 possibilities.

12 PARTICIPANT: Go to the mike.

13 DR. WEISSMAN: Oh, I'm sorry.
14 That there probably are a lot of different
15 possibilities for how you look at this.

16 But there are, you know, starting
17 from the simplest, there are some measures for
18 which are already stratified and declare data,
19 and you start from there.

20 And then after that you've got a
21 lot of different scenarios. And I think what
22 we were pointing out here is that there may be

1 some situations where either the measure has
2 not been stratified by race and ethnicity, or
3 maybe it has and it's not showing disparities.

4 And yet there's a suspicion that
5 actual disparities should miss, maybe exist
6 that for some reason or another this measure
7 is missing something that one might suspect
8 based on either these other criteria or based
9 on other literature that something exists.

10 So I think there are a lot of
11 different ways to go beyond that. I'm sorry
12 if that wasn't as clear as it could be.

13 DR. MCCADE: I actually want to
14 echo what Luther just said. My suspicion is
15 that of the 700 measures, not all are going to
16 be equally important and have equal impact on
17 outcomes.

18 And I think if you want to try to
19 find something that is going to be relevant,
20 as Romana just spoke about and what Marshall
21 was going towards before, I think what the
22 practicing physician wants to see is that when

1 I do something, it actually has an impact on
2 the care that I provide.

3 And so maybe that should be a
4 stratification criteria of the 700. The
5 ability to actually have an impact in the
6 measurable fashion that physicians can even
7 see, and perhaps be encouraged to continue
8 culturally based thinking in terms of what
9 they do in their practices. And I think that
10 may be one approach to do this.

11 And I think the idea of creating
12 sentinel measures is also important, and
13 although that's not what we're focusing on at
14 this second, it's on the slide so I thought
15 I'd go there.

16 When I first read it I wasn't
17 quite sure as to what was called for at that
18 point, but now I think I'm developing a better
19 understanding for it after hearing a bit of
20 discussion and thinking about it a little bit
21 more deeply.

22 And that there are some things

1 that potentially the 700 measures don't
2 account for. And I think this committee has
3 a lot of expertise and could potentially be
4 very useful in trying to identify those
5 particular areas.

6 And as the call comes along to
7 create a request for these additional
8 measures, we could be very instrumental in
9 helping to identify specific things that could
10 be important in that regard, both impact as
11 well as visibility and measure in a
12 responsible way.

13 DR. WASHINGTON: So going back to
14 what Marshall said about thinking about how
15 these measures are used. I think that part of
16 the challenge is that they're used many
17 different ways. And that different health
18 care systems are at very different stages in
19 both their gathering and reporting of the data
20 and how they use it.

21 I mean despite sort of the best
22 efforts to admonish organizations on how to

1 use the status, some may potentially misuse it
2 and sort of target resources, since most
3 organizations don't have new resources, then
4 addressing disparities which is obviously a
5 goal, might come at the cost of shifting
6 resources from some other area.

7 And so they'll make the
8 disparities maybe for the targeted measures go
9 away, but if you don't continue to then
10 monitor them as they then shift to other
11 things, those disparities will come back.

12 So I think it's important in
13 thinking about the point about measures that
14 show no disparities, that though they show no
15 disparities issues, disparities may recur in
16 future years.

17 And so I would not necessarily
18 solely use that as a criteria for including
19 versus not including stratification for a
20 particular measure.

21 The other thing is I really want
22 to reiterate that I think there's a very

1 important role for adding measures,
2 particularly the four bullets that are up on
3 the slide, and thinking about organizations
4 that have gotten it that they have to measure
5 report on disparities. Then the next
6 challenge is how to translate the gap in
7 reducing process measures in reducing the
8 disparities and outcome measures.

9 And I think some of those missing
10 steps, some of the missing links have to do
11 with communication, and have to do with some
12 of the other things that we're not currently
13 measuring. So I would encourage us to move
14 forward with encouraging some of those new
15 measures.

16 MS. CUELLAR: I just wanted to
17 mention when you're looking at measurement as
18 well, the government has put out the carrot
19 out there for electronic medical records, and
20 one of the things we might consider is
21 partnering in as this moves forward.

22 Because from assessment tools to

1 providing education, to providing things that
2 are health literate appropriate, that's a
3 potential route for this and there is a lot of
4 grants out there.

5 A lot of the health organizations
6 are taking advantage of this carrot that has
7 been put out there for monies to become more,
8 as a country going towards the total
9 electronic medical record, and starting from
10 admission all the way to the continuum of
11 care.

12 I think that's a great avenue that
13 perhaps partnering with them, might provide
14 not only an avenue but of capturing the data
15 as well.

16 CO-CHAIR ANDRULIS: Elizabeth, and
17 then Marshall?

18 DR. JACOBS: So I thought Marshall
19 was next. I probably don't need to say this
20 but there's a lot of ideas going around here.

21 I really want to act on something
22 I think either Mary or Collette said about,

1 we don't want to make people more negative
2 about thinking about these issues around
3 providing equitable care, and we can do that
4 if what we ask for is so burdensome.

5 So I keep hearing 700 measures and
6 I'm going, oh my god, how are we going to
7 narrow that down? Because it's just, we have
8 to somehow figure out a way to bring it down
9 to a way that it would be more user friendly
10 to people.

11 So it wouldn't be necessarily
12 perceived as more of a burden and again kind
13 of marginalized disparities again as we've
14 talked about, or make them viewed more
15 negatively or continue to perpetuate that
16 view. That is not something we should care
17 about, or it's just another thing we have to
18 report. We don't, it's a burden.

19 DR. CHIN: So as of a point of
20 information in the comment that maybe Helen,
21 and maybe Joe, can comment upon, you know, so
22 this Measures Application Partnership that NQF

1 is working on was charged by Congress as part
2 of an ACA to recommend performance measures
3 for reimbursement and public reporting.

4 And so that, you know, one of the
5 first things it's designed to do is to
6 basically create common measures across like
7 all the federal agencies, so like HRSA and
8 NCMS, et cetera.

9 Which you know if that does work,
10 you know, will be like a 800 pound elephant in
11 the room in terms of, you know, getting
12 everyone on the same page, and the private
13 partners, private insurers would follow also
14 in terms of everyone would love to have some
15 uniform data set.

16 So if it does take off, I mean it
17 will be very powerful. And Liz like in the
18 subgroup, on the commission subgroup, it's a
19 very similar list of criteria that people have
20 been throwing around that, it looks like it's
21 slide two or three, it's the last one Joel
22 had, you know, like prevalence and

1 actionability and morbidity, et cetera.

2 These are exactly the same, you
3 know, terms that they've been throwing around
4 now as like, at least in our subgroup trying
5 to come up with an, you know, criteria for
6 thinking about the measures that can be
7 chosen.

8 So again this issue of trying not
9 to like duplicate and reinvent the wheel. I,
10 you know, like Helen and Joe's on the
11 steering, overall coordinate committee for
12 this MAP, if it does seem like this was going
13 to work in terms of there be consensus, and
14 all these big players at the table in terms
15 of, you know, being buy-in for this.

16 In some ways it would be nice to
17 be able to wait until, you know, there was
18 that list of 45 measures or 100 measures as
19 opposed to being up to 700.

20 My guess is that a lot of the
21 measures that we'll be coming up with, really
22 are going to the usual suspects. Because like

1 the last meeting we had, the usual suspects
2 are the usual suspects for good reason. I
3 mean if the prevalent conditions that cause a
4 lot more morbidity, that existing measures,
5 that are feasible to measure, my guess is then
6 that a lot of them are going to be sort of
7 versed in with the ones that Mary talked
8 about.

9 But in terms of this committee,
10 the big hole is going to be the things that
11 aren't on the list of 700 right now.

12 So the things that do become in
13 some ways particularly, you know, our venue
14 that other people won't think about because
15 it's just not as high priority, so mainly
16 things like interpreter services, and limited
17 health literacy measures.

18 Or some of the potentially, like
19 the pathway things that, like you can get for
20 example, a transplant, and there are some nice
21 examples, there's a lot of pathway
22 communication things that are on the list that

1 may not be coming to mind initially in terms
2 of more broadly people thinking about
3 performance measures.

4 So part of the question for Joe
5 and for you Helen is, well, you know, how do
6 we minimize duplicating the wheel that again,
7 if it's going to be sort of big work by some
8 ways, you know, bigger umbrella that, I've got
9 to come up with the same measures at least for
10 part of the subset.

11 You know, it would be a lot of
12 work for us to duplicate what will be 80
13 percent of the same in terms of the existing
14 measures versus us thinking about some of the
15 things that would fall through the cracks by
16 the other committees, not because they're bad
17 committees but because that's not their
18 priority, thinking about disparities.

19 So is it a mistake to say well,
20 you know, let's not duplicate what's going to
21 be the duplication anyway in terms of what
22 they're going to come up with, and of course

1 think about the very specific things.

2 Or is that dangerous in terms of
3 saying well, we can't rely upon the MAP coming
4 up with the measures and issues that we would
5 think would be important? And so that we
6 should go through this big process of going
7 through the 700 and thinking about, you know,
8 what are the things that are directly relevant
9 for us.

10 I mean I just don't want us to do
11 a lot of work that's going to be basically
12 wasted work potentially.

13 DR. BURSTIN: I'll start. Joe, if
14 you want to add in anything, please do so.
15 This MAP is new. We are just beginning this
16 process. We've just literally done a draft
17 set of criteria. You don't see a draft of
18 course that they've been started, I think
19 they're through a clinician group.

20 I still think, and again I don't
21 have any great need to go back through each of
22 the 700 measures and do this determination.

1 If that's not necessary, that's not necessary.

2 That's my first question to you
3 guys. Do we need to do any of that? I mean
4 that's the real issue here. We did it for
5 ambulatory care. We didn't do it for anything
6 else.

7 Having just that in ESRD committee
8 sure feels like to me, ESRD is one of those
9 places you'd want to say boy, if you get a
10 look at these measures, make sure that the
11 CROWNWeb, the system CMS uses for ESRD
12 includes the data to be able to stratify.

13 So I'm happy to have you guys
14 think this through however it makes the most
15 sense in terms of the lens. It's a condition.
16 Is it somebody's cross-cutting issues that
17 have been raised?

18 I would not rely on the MAP to
19 come up with the key ways we want to look at
20 the measures that come to NQF for endorsement
21 around disparities.

22 I still think that 's going to be,

1 they're relying on this process for the
2 selection. It's still the next step in the
3 process.

4 I do, however, think it's
5 critical, and I know that's a big portion of
6 tomorrow, that I definitely want this
7 committee to tell us, what are those kind of
8 sentinel cross-cutting disparities measures
9 and cultural competency measures that we
10 should bring in? That's not an either/or to
11 me, that's an and, and we need to do both.

12 I still want to be able to hold
13 people's feet to the fire to be very honest,
14 when a measure's up for maintenance. What do
15 they have to give to NQF? What do they have
16 to show us that they've at least been thinking
17 about the disparities issue?

18 Because if we don't, it won't come
19 up. I mean if it wasn't for people sort of
20 really pushing on the issue and insisting on
21 it, I mean do you want NQF endorsing measures
22 of low birth weight and not having somebody

1 raise the spectra of saying boy, if there was
2 ever a measure you'd want to stratify, this is
3 it.

4 It's just really a question for
5 you as we go through our process, that's
6 endorsement of measures is still the first
7 step before selection of measures.

8 And I don't want it to be viewed
9 as something that's an either/or. But you
10 could at the same point say that as a
11 principle whatever gets prioritized by the
12 National Quality Strategy or by the, you know,
13 Measures Application Partnership, should
14 definitely be stratified.

15 I mean that's one approach, saying
16 the measures that are prioritized should
17 always be stratified, maybe that's one
18 different approach to looking at this.

19 CO-CHAIR ANDRULIS: Joe, do you
20 have any comments?

21 DR. BETANCOURT: No, I think
22 that's exactly right. I mean I think the MAP

1 is, you know, trying to find its sea legs.
2 And I stood on that. This has occupied a lot
3 of my oxygen around measurement in the last,
4 you know, couple months.

5 But I think now that this process
6 is underway that we have at least a paper.
7 I'd like to offer to present it to that group
8 so that they can at least wrap their mind, I
9 mean they're dealing with a lot of very, we're
10 still at probably 50,000 feet, and this is
11 probably down a bit.

12 So I'm committed to and I think
13 certainly Helen as well, committed to keeping
14 it in there. But I think it's going to more
15 an integration as it goes, and I think we'll
16 do a good job at trying to prevent
17 reinvention. But it's going to be a very
18 iterated process. That's a long road yet, a
19 couple years perhaps.

20 DR. WEISSMAN: And I guess this is
21 almost as much of a question as a comment, but
22 in the same sense that there are 700 or so

1 measures that currently exist in NQF, and MAP
2 is coming up with a subset of those.

3 So just because the 700 exist
4 doesn't mean that an ACO or other organization
5 has to select all those, but NQF is coming up
6 with a recommended subset that are really
7 important and that should be used in a lot of
8 different situations.

9 And my understanding is that there
10 is a parallel charge here. That if your
11 organization is interested in either reporting
12 on disparities, or incenting on disparities
13 behavior, here is a subset of measures that
14 you might think about using. Is that a good
15 way to state it?

16 And almost by definition then,
17 you're saying that the charge of this
18 committee is really to come up with a subset
19 that would be a focused subset that would
20 represent the experience in disparities. It
21 wouldn't be perfect. It wouldn't be
22 everything, but it would be something to focus

1 on.

2 DR. BETANCOURT: You know, say our
3 bringing up the 700 was more from the
4 standpoint of, you know, it's a spectrum,
5 right, for consideration for the committee.

6 On one end, you know, you're
7 thorough. You go through all. You've got
8 them all and you pick, you know, and there's
9 a whole spectrum of different things I think
10 you could do there.

11 I don't think it's, you know, our
12 firm recommendation that you start and look at
13 all the 700. I think the committee, it's up
14 to you all to decide which way to go, but
15 that's, you know, from the most thorough to a
16 couple of different approaches in between is
17 what's I think at your disposal.

18 CO-CHAIR ANDRULIS: Ellen? Well,
19 I think that's the question we're going to
20 come back to, you know, that's what we'll
21 probably vote on in some way, shape or form,
22 is your point. Yes, Ellen?

1 MS. WU: I just want to say I
2 really appreciate Helen's approach to this and
3 it feels, I mean, you know, 700 how ever many
4 numbers of measures, I don't know if it's
5 necessarily the point in that more so,
6 whatever standards are established it somehow
7 changes the culture and the way we do the work
8 and how we look at it.

9 So it's not an added effort,
10 right, to do this disparities as work. It's
11 part of a health systems kind of every day
12 process.

13 And I don't, you know, I think the
14 way you articulate it in terms of new measures
15 coming in or whatever, always having that lens
16 on it is great.

17 So how ever we get there, through
18 the measures or whatever other standards that
19 are set, I think that's really where I would
20 like to see, the kind of the eye on the prize.

21 You know, it could be two, but if
22 it changes the system in a dramatic way, that

1 would be huge, right, in just how they do
2 every day processes. And I don't know what
3 that is, but I just --

4 CO-CHAIR ANDRULIS: Okay. I think
5 Elizabeth, I think you had your, oh, and now
6 it's down. Oh, thank you. Donna and then
7 Romana?

8 (Off microphone discussion)

9 CO-CHAIR ANDRULIS: Pardon, and
10 then break for lunch. And Ernie and that's
11 it.

12 DR. WASHINGTON: So 700's a big
13 number for us to sort of wrap our, at least
14 for me there it's sort of wrap my mind around.
15 And so I was looking again at the framework in
16 this paper, which I think is really a useful
17 starting point that thinking about structure
18 process and outcome, sort of where the 700
19 measures fit in that framework. And also more
20 importantly, thinking about the roots of the
21 disparities.

22 So if we really want something

1 actionable, if the end result of this whole
2 process is not just better measurement but
3 taking that better measurement and using it to
4 eliminate disparities, then maybe the approach
5 is to think about which things do we have the
6 greatest impact to change.

7 And so, for example, you guys list
8 the roots of disparities as provider based,
9 patient based, system based, or related to
10 health insurance. We know a lot is happening
11 with the Affordable Care Act.

12 I think we've agreed that some of
13 the patient based social determinant, it's
14 extremely important to stratify on those
15 things, but perhaps it's the provider based
16 and health care system based that the health
17 care systems had to reporting this stuff out,
18 have the greatest ability to change.

19 And so as a starting point I would
20 recommend looking at those system based and
21 provider based measures. And then also, a mix
22 of both the condition specific and cross-

1 cutting.

2 The thing I like about the cross-
3 cutting measures is their potential to perhaps
4 influence multiple measures.

5 CO-CHAIR ANDRULIS: Where are we?
6 Ernie, Ernie?

7 DR. MOY: Okay, I think I had two
8 comments. One was hearing a lot of things
9 around the table I think that were meant to
10 try to protect the measure user, and the 700
11 comes to mind. But what are we going to do
12 about that?

13 But I think many of your
14 recommendations we're talking about are
15 actually for the measurer suppliers, then the
16 measurer developers.

17 I don't think anybody uses all 700
18 measures, and if they do they take out which
19 ones they want to use, right.

20 And so I don't really have a
21 problem with saying well, for the measure
22 developers that they should consider

1 stratification of these measures.

2 Generically, it's not a burden on the measure
3 users, they still get to pick what they want
4 to use.

5 I did like the notion that was
6 raised, which was I think the notion of a
7 starter set for disparities measurement. That
8 would kind of hone things out.

9 But the more I thought about it I
10 had some reservations, which are simple
11 observations looking at disparities and it's
12 variation, is that there are certainly some
13 disparities that are highly prevalent across
14 geographical locations, but they vary
15 tremendously.

16 And there are simply some places
17 where they have less of one disparity and more
18 of another disparity. And so I hesitate to
19 restrict the starter set because it may not
20 truly capture all the disparities that are
21 there.

22 I think maybe an alternative

1 approach is to specify criteria for an
2 organization to think about when they're
3 selecting disparities measurement for
4 themselves.

5 Or even a generic statement, yes,
6 users should consider the issue of
7 disparities, which is a very general kind of
8 comment. But that would be a recommendation
9 I would favor it more.

10 CO-CHAIR ANDRULIS: It goes back
11 to that guidance for how you select, and how
12 you don't just go by the starter set. You
13 know, choose and learn how to use it for your
14 organization, and what measures would be
15 relevant for your setting. Yes, very simple,
16 and a good starter set for one place, would
17 not be a good starter place for some other
18 place.

19 DR. MOY: Yes, good starter set
20 for some other place.

21 CO-CHAIR ANDRULIS: Absolutely.
22 Romana, I think you, no? Marshall, are you

1 back up again?

2 DR. CHIN: Yes, just a question
3 for like, who does what? And what does the
4 work in this committee, be it versus NQF's
5 fantastic staff versus no one doing the
6 details and it's a more general
7 recommendations.

8 In other words, is the goal at the
9 end of the day to have then a list of, for
10 example, let's say if it turns up there were
11 30,40 disparity measures that, you know, is
12 the end product.

13 You know, which involves, for
14 example, if we went through like MGH's
15 recommendations, that's a really extensive
16 process that is going to know, like well, is
17 that the goal? And if that's so, then what
18 does this committee do versus NQF staff?

19 So I guess it's about the charge.
20 What is the end product and what specifically
21 do the people at the table expect it to do,
22 versus NQF's staff versus, you know, some

1 other entity?

2 MS. MCELVEEN: Sure. Well, the
3 goal was, and Mass General proposed obviously
4 this algorithm and measure selection. Taking
5 that information and applying it to all 700
6 measures would not be a charge of the
7 committee.

8 That would be something that NQF
9 staff would do initially. If then we come to
10 a resolution say okay, out of all 700 we found
11 50, we then would present that to the group
12 and say okay, this is, you know, the output of
13 our work, what do you think? That's all I
14 have.

15 MS. NISHIMI: Right. So having
16 said that, that's why we're focused on having
17 you try and identify the criteria that you
18 want us to filter these measures through.

19 We've heard support for the
20 general categorizations scheme, you know,
21 process, outcome, structure, provider, system
22 based, you know, patient experience. So I

1 think that part is clear in our mind.

2 And maybe we could take the break
3 for lunch now, and come back and hone in on
4 some of those criteria Mass General has teed
5 up.

6 You know, that there be a primary
7 focus on prevalence and the quality gap that
8 I heard, you know, some question about also.
9 The degree to which it's actionable. Some of
10 that's going to fall out again, the
11 categorization scheme, but we need the
12 committee's best input at this point, really,
13 you know.

14 Robyn, Nicole, Kristen, Elisa, if
15 you focus on prevalence and quality gap that's
16 going to float the most important ones to the
17 top. We can categorize them out when they
18 come back, or if there are other things that
19 you need us, filters that you need us to
20 apply.

21 So if you can think on that
22 notion, when we come back we can address that

1 and then start addressing some of the other
2 micro issues that we need to get through
3 today.

4 CO-CHAIR ANDRULIS: So we'll take
5 a 30-second break for lunch. I think lunch is
6 on outside.

7 MS. NISHIMI: Yes, so I think the
8 notion was for, you know, folks to take a
9 break, return whatever calls you need to do,
10 get your lunch, and then come back in here.

11 CO-CHAIR ANDRULIS: Come back and
12 we'll pick it up after a bit.

13 MS. NISHIMI: Because we will have
14 a working lunch.

15 CO-CHAIR ANDRULIS: Absolutely.

16 (WHEREUPON, the meeting in the
17 foregoing matter went off the record at 12:43
18 p.m. for lunch and back on the record at 1:12
19 p.m.)
20
21
22

1 A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

2 (1:12 p.m.)

3 CO-CHAIR ANDRULIS: So to start
4 off the afternoon, what we want to do is I
5 want to draw your attention to the PowerPoint
6 that's up on the questions that we and NQSF in
7 particular have put together that are meant to
8 be a digest of a capturing of the conversation
9 that we have had as well as we're, they would
10 like this advisory group to go.

11 Please, yes.

12 DR. NUNEZ-SMITH: Okay, so I was
13 just trying to recap, and before we talk about
14 this slide think a little bit about
15 summarizing what I thought I heard over the
16 first half of the session.

17 And I walked away thinking that we
18 as a community are sort of tasked with three
19 domains of work.

20 And the first one I thought of
21 was, is to come up with some overarching
22 principles, perhaps some position statements.

1 And the notes I took were, one,
2 potentially all prioritized measures should be
3 stratified.

4 That all measures coming up for
5 recertification should be stratified, but also
6 thinking about how disparities might be
7 distinct entities within institutions, and
8 therefore the uptake of measures may vary by
9 institutions and systems. So that one of our
10 charge is to think of some broad position
11 statements such as those.

12 And then separate from that it's
13 really perhaps criteria development more than
14 measure identification per se in that other
15 two domains, which was thinking about a
16 starter set around the existing measures that
17 we're sort of calling the 700 right now.

18 And then thinking about criteria
19 for sentinel measure development and those
20 ideas that might be new, but within a context
21 of ability to implement successfully, uptake,
22 be actionable and feasible.

1 But I just wanted to make sure
2 that that was sort of the consensus of the
3 group as to where we were headed into the
4 afternoon, and if I'm off then to be sort of
5 redirected back on track.

6 MS. NISHIMI: Okay, if I could
7 just clarify something. We're going to get to
8 issues of stratification in some of these
9 principles when we get to the long list of
10 questions that's on the second page of the
11 agenda.

12 So I agree that we need to come up
13 with some principles on what we need to, what
14 our expectations are for reporting and how
15 they should be reporting.

16 I don't want to launch down that
17 path right now and try and identify
18 principles, because that's part of the
19 afternoon's work is to identify these
20 principles not just around stratification but
21 also about reference population, et cetera.

22 DR. NUNEZ-SMITH: So is it fair

1 then to say that we are sort of doing both
2 things which is coming up with these
3 overarching principles?

4 MS. NISHIMI: Yes, there were
5 overarching, cross cutting recommendations.

6 DR. NUNEZ-SMITH: As well as
7 specific criteria around measure
8 identification, measure development?

9 MS. NISHIMI: Right.

10 DR. HASNAIN-WYNIA: I'm being very
11 simplistic, but I want to get back to the 700
12 and I'm trying to understand.

13 Of the 700, 135 in the last round,
14 the ambulatory disparity, 30 -- no, I'm sorry.
15 There were 135 or a hundred and something
16 ambulatory measures total at the time. Of
17 those, 35 came forward and were endorsed by
18 NQF, right.

19 DR. BURSTIN: Came forward and
20 were designated as disparity sensitive.

21 DR. HASNAIN-WYNIA: Disparity
22 sensitive, okay. So what we have of the, kind

1 of if we subtract that number, we still have
2 quite a few measures that are not ambulatory.
3 So they're either inpatient, long-term care,
4 et cetera, or they're ambulatory again?

5 MS. NISHIMI: Or additional
6 ambulatory.

7 DR. HASNAIN-WYNIA: Or additional
8 ambulatory. So what I was trying to do is see
9 if we could get to a point where we know that
10 we've already vetted a number of measures, but
11 it doesn't look like that happened because
12 there's an additional list.

13 DR. BURSTIN: All measures are now
14 going through measure maintenance at this
15 point, so that that's why this is an opportune
16 time for us to think through, what would we
17 want to see as those measures are re-vetted in
18 addition to what we want de novo measures to
19 bring to the table, whether they're the
20 disparities sentinel affects the direction we
21 go or the more cross cutting ones, what would
22 you want to see them bring to the table?

1 DR. HASNAIN-WYNIA: Okay, so I was
2 trying to make sense of kind of what we were
3 working with when we, in terms of answering
4 this question for you all about whether the
5 staff should be reviewing the existing 700-
6 plus measures to identify those that are
7 disparity sensitive, which does not identify
8 the sentinel disparities measures, only the
9 disparity sensitive, right. Okay.

10 MS. McELVEEN: That's correct, and
11 thank you, Romana, for leading us into our
12 next discussion point.

13 So what we wanted to do as quickly
14 over the break, we just came up with a few
15 basic questions to kind of figure out where
16 the committee is in terms of consensus around
17 some basic ideas that we need to iron out
18 before we move any further.

19 So the first was just mentioned.
20 It's up on the screen. Should NQF staff
21 review the existing portfolio, and that's the
22 700-plus measures, to identify a disparity

1 sensitive subset?

2 MS. NISHIMI: Show of hands.

3 MS. McELVEEN: Show of hands.

4 MS. NISHIMI: Yes, okay.

5 MS. McELVEEN: Okay, so that's a
6 yes. And if the committee agrees with that
7 the next question is what criteria should be
8 used?

9 Recommended within the commission
10 paper are the criteria of prevalence and
11 quality gap. If you agree with that we will
12 use that. And in addition, is there anything
13 else besides the prevalence and quality gap
14 that should be considered?

15 DR. MOY: Can I ask a clarifying
16 question? By prevalence do you mean overall
17 prevalence, prevalence in whites, prevalence
18 in blacks, differential prevalence, and the
19 same for quality gap?

20 MS. NISHIMI: I'm trying to
21 remember what the papers specified. I think
22 the paper was prevalence within, so something

1 that was more prevalent in a minority
2 population would rise to the top.

3 DR. MOY: Delta prevalence and
4 same for quality, delta quality?

5 MS. NISHIMI: Yes. Assuming,
6 yes.

7 DR. MOY: So greatest of whatever
8 tracked populations there are.

9 MS. NISHIMI: Right. Another
10 clarifying question?

11 DR. McCADE: So under anything
12 else, I think there are a couple of things
13 that should be considered. One of them is
14 that is the measurement easy to obtain, or not
15 easy to obtain but not burdensome to obtain
16 for practicing physicians or for systems if a
17 record.

18 And the other thing is prevalence
19 is an interesting concept, but maybe we should
20 look at potentially financial impact in terms
21 of the ability to change cost of care with
22 respect to the intervention that's made.

1 MS. NISHIMI: Okay, with respect
2 to the former, I think that was actually part
3 of some of the original criteria. So I think
4 applying that filter is not an issue if the
5 committee agrees.

6 With respect to the latter, I
7 don't think we have data that we're going to
8 be able to, I don't disagree that that would
9 be a good filter, it's just that I don't think
10 we have the data to be able to apply that
11 filter.

12 DR. HAVRANEK: Just as an
13 additional criteria, I wonder if the idea of
14 public impact should be brought in. That
15 there are some conditions that have more
16 impact on the public that capture people's
17 imagination more than other conditions.

18 So if you compare disparities in
19 mortality rates for breast cancer, I think it
20 has more of a public impact than does
21 differences of mortality or hospitalization
22 rates say for heart failure.

1 And, you know, I think one of the
2 things that's been missing in this discussion
3 is a sense of what the community feels is
4 important.

5 That, you know, it's one thing to
6 come up with a list of stuff with a bunch of
7 people in suits in a expensive hotel in
8 Washington. It's another thing to think about
9 what people in minority communities think is
10 important. And I'd just really like to see
11 that issue and that voice brought into this.

12 CO-CHAIR ANDRULIS: It's a
13 question of measures in context. You know,
14 what are the contexts that are relevant to the
15 way this information coming from NQF would be
16 received.

17 So community context, political
18 context, social context, other contexts that
19 are key to interest, understanding,
20 application.

21 DR. HAVRANEK: Yes, I think that's
22 right. I think that, you know, if those whole

1 field is going to move together then there has
2 to be some, you know, ground swell of support
3 for it. There has to be some sort of
4 underlying support for it.

5 This can't be a set of esoteric
6 measures that are interesting to, you know,
7 quality wonks. I mean I think this has to be
8 something that captures the imagination of
9 people who are, sort of push their physicians
10 and hospitals and all that other sort of stuff
11 to make some fundamental changes.

12 MS. NISHIMI: Okay, so impact was
13 one of the original criteria, so it sounds
14 like --

15 DR. HAVRANEK: I guess I'm
16 advocating for making that be one of the
17 fundamental things.

18 MS. NISHIMI: So does anyone, can
19 we have a show of hands? Does the committee
20 agree that impact should be a criterion that's
21 considered when this NQF staff applies its
22 filter?

1 DR. WEISSMAN: Can I make a
2 comment? We went through some of the same
3 discussions. The impact, usability,
4 feasibility, all those sorts of things, they
5 already exist. That's how measures getting to
6 NQF.

7 The principles, and I don't know
8 how different principles are from criteria but
9 so be it, that were from the 2008 report, each
10 one of them there's some overlap but they
11 referred to impact on the minority population,
12 right, feasibility and ability to affect
13 quality processes on the minority population.

14 So and we think that's important
15 too, but just to make sure that the discussion
16 goes in an efficient way, I think people ought
17 to realize that there's overall impact which
18 gets a measure already selected, which we
19 assume all these have already gone through
20 that filter.

21 And then there's this additional
22 one about, you know, impact on the minority

1 population, ability to improve quality of care
2 in the minority population and so on. That's
3 what these principles are focused on. And we
4 just were emphasizing prevalence and gap but
5 the other ones make sense. It's not that they
6 don't make sense.

7 MS. NISHIMI: Thanks. No, that's
8 important, so all appreciated.

9 CO-CHAIR ANDRULIS: Ellen and then
10 Marcella.

11 MS. WU: Just to be able to learn
12 from past experience, what were the criteria
13 that was used for the ambulatory care
14 screening and how did that work out?

15 MS. NISHIMI: The four were
16 quality gap, prevalence, the impact of the
17 condition, impact of the quality process and
18 actionable, ease and feasibility of improving
19 the quality process.

20 How did it work out? It depends
21 on where you sat. Some people thought there
22 were too measures, some people thought there

1 weren't enough. So I can't provide you
2 anymore guidance other than it really
3 depended. Some people thought 35 was just way
4 too many and others were unhappy that it
5 wasn't a broader set.

6 CO-CHAIR ANDRULIS: Marcella, then
7 Mary, then Marshall.

8 DR. NUNEZ-SMITH: My first comment
9 is really linked to that because I was going
10 to ask if there's any utility in thinking
11 about a target number for us as a group as to
12 what was a good size for our starter set or
13 whether we wanted to revisit that later.

14 But there probably is some range
15 that is reasonable, and I also was thinking
16 around that 30 to 40 that the ambulatory team
17 came up with.

18 And then my other thought was, I
19 mean I agree that we should probably be
20 starting whether it's the delta, but just for
21 the record, to say that the point was made
22 several times this morning that often where

1 there is no delta existing currently doesn't
2 mean that's not an important place for us to
3 look in the future for disparities or that we
4 just might not have good enough data in that
5 area yet.

6 So to have some caveat where, for
7 us to consider that there might not currently
8 be a delta, but there is either overwhelming
9 impact or something else that makes us think
10 that's an important criteria or standard.

11 DR. MARYLAND: So I guess I would
12 ask because I hear what's the impact, how do
13 we overlay a lens of what's the state of the
14 science that could impact what could be a very
15 emotionally charged issue?

16 As an example, in disparities one
17 might think about prostate cancer incidents
18 and the issue of whether or not you should
19 screen, and there's lots of debate.

20 So what is the state of the
21 science for it, and we have to be I would
22 think socially responsible in terms of

1 thinking about cost benefit analysis. Do we
2 advocate for what we think the public wants to
3 hear as we should do something versus has the
4 needle moved and we now should be thinking of
5 what does the science say we should do?

6 And I guess as we think about
7 these things, I want us to consider what's the
8 best in terms of what we know scientifically
9 in discussing what could be a very emotionally
10 charged issue.

11 DR. CHIN: I just drew a blank.
12 Oh, so the question really having to do with
13 like what is practical from the staff's
14 perspective that I think like all the items
15 that Joel and Joe had on the slide are great
16 elements. Some of them start getting hard to
17 operationalize.

18 So for example, prevalence and
19 quality, very straightforward I think for a
20 first, the staff to go through. Something
21 like impact is tougher.

22 And I agree with Mary that it

1 should not be politically based, at least the
2 data we get, but based upon, you know, the
3 science. Or something like actionability,
4 that's another one where it's not as obvious
5 as prevalence or quality gap.

6 So it's so much what is feasible
7 for the staff. So it may turn out, for
8 example, that if you still get to a reasonable
9 number just using the simple ones like
10 prevalence and quality and then, you know, if
11 a reasonable number are then sent back to this
12 group, then the group can probably, you know,
13 fumble around with the ones that are hard to
14 operationalize like actionability and impact
15 and all.

16 But if there's still a large
17 number then maybe you guys need to then
18 include us in the filter.

19 MS. NISHIMI: That would
20 certainly be the approach that I think we want
21 to take even if you hadn't recommended it.

22 DR. CHIN: Okay. I mean another

1 issue too is like, and everyone will remember
2 this when the ILM made recommendations
3 recently to AHRQ in terms of equality in
4 disparity reports, one of the major concerns
5 with the kind of reports is that we didn't
6 have prioritization.

7 So that you basically have 200
8 measures and so no one knew where to start.
9 And so that's still potentially the danger
10 here unless, and particularly the impact part
11 is brought in.

12 That, you know, prevalence and
13 quality are one thing but, for example, if
14 there's a big quality gap in, you know,
15 measuring Alc for diabetic patients, that's
16 probably a less important measure even if it's
17 a big gap, than something that has a more of
18 a direct public health effect like, you know,
19 an actual outcome as an example.

20 CO-CHAIR ANDRULIS: Francis and
21 then Mara.

22 DR. LU: Just a very simple

1 question. I may have missed it obviously, but
2 the five criteria that were used in the
3 ambulatory report that Helen, not Helen but
4 Ro mentioned earlier, I'm just wondering could
5 those be the five criteria that we use here as
6 well? I guess I'm missing something there.

7 MS. NISHIMI: Well, and that's
8 the recommendation from MGH, was that on
9 balance we should focus on prevalence and
10 incidents as we screen now across this
11 portfolio.

12 Recognizing that when NQF endorses
13 measures it considers a lot of these other
14 things writ large, so some emphasis.

15 DR. BURSTIN: Especially as the
16 endorsement criteria have been getting harder
17 and harder over the last several years, a lot
18 of these other things are part and parcel
19 impact as one of the must-pass criteria and
20 for all measures.

21 So it doesn't need to be in this
22 dataset. I think a criteria is what the MGH -

1 -

2 MS. NISHIMI: Yes, I think the
3 impact on viewing it from the disadvantaged
4 population is slightly different. So but let
5 me see if I can -- oh well, you had two other
6 people and then let me see if I can frame the
7 question.

8 MS. YOUDELMAN: Well, and it might
9 be a similar question. So when the ambulatory
10 measures were evaluated and you got down to
11 35, was it because the other hundred really
12 weren't at all relevant to disparities or it
13 was sort of a prioritization or, that's what
14 I'm sort of struggling with is how to
15 understand like why 35 made it and a hundred
16 didn't versus, you know, yes, that.

17 MS. NISHIMI: Yes, it was more or
18 less a prioritization. I mean, you know,
19 folks didn't feel that however all 20 or 12 or
20 how many diabetes measures were in the set at
21 that time, all had to be considered disparity
22 sensitive. In fact, I don't even know if any

1 of the diabetes ones are in there. I'm just
2 making this up relatively speaking.

3 So once they created a set they
4 winnowed down and said, you know, if you're
5 going to measure one aspect of X care, you
6 know, these one or two measures of a set
7 that's, you know, 12 or 15 or 20 are the most
8 important issues.

9 MS. YOUDELMAN: So let's just use
10 20 diabetes' as an example, and regardless, 20
11 of X. So if there's 20 of X do they always
12 have to report on 20 of X or do they get to
13 pick and say, I'm doing two of X and
14 reporting?

15 MS. NISHIMI: Who chooses what to
16 implement is a separate issue.

17 MS. YOUDELMAN: Okay, because I
18 guess I'm also trying to figure out, if you
19 have 20 and, you know, the question is, is it
20 become a huge, you know, obstacle for folks
21 versus we're sort of moving forward with
22 electronic health records and everything?

1 So if you're collecting race,
2 ethnicity and language once it should be
3 available for how ever many measures you have.
4 But again I think that might be sort of my
5 simplistic understanding of it.

6 But I'm trying to sort of grapple
7 with this, you know, not putting a burden on
8 it, not creating a negative impression of
9 addressing disparities, but also are we really
10 almost stratifying ourselves more than we have
11 to by saying we're only going to pick and
12 choose certain measures?

13 MS. NISHIMI: We're not going to
14 pick and choose what people should implement.
15 Folks who are implementing would pick and
16 choose amongst this.

17 But we are winnowing down the 700
18 to say, you know, for the time being right now
19 because we don't have, you know, all of our
20 systems in place to make this seamless as part
21 of, you know, an analysis for any entity to
22 just push button because, you know, they

1 collect race and ethnicity.

2 They collect all the data elements
3 for these measures so, you know, doing one is,
4 and pushing the button is no different than
5 pushing the button and, you know, getting a
6 read-out for 50.

7 We're not at that place yet, so
8 what we're doing is identifying the measures
9 that you may wish to look at when you're
10 looking at disparities within your system.

11 MS. YOUDELMAN: So is part of the
12 evaluation then, if someone else is requiring
13 it for implementation currently that it should
14 rise higher for us in terms of prioritizing
15 because it's being used then therefore we
16 should have this data collected?

17 Like if there's 20 disparities
18 measures and CMS is requiring two, should we
19 be thinking about saying well, those two
20 should have race, ethnicity, language because
21 they're already being required elsewhere and
22 the other 18 aren't. Like is that a way to

1 splice this or not?

2 MS. NISHIMI: Well, yes and no,
3 because we don't select the measures. At the
4 end of the day CMS does. We make
5 recommendations through this new process
6 called the MAP, but at the end of the day the
7 end users, the health plans, CMS and others
8 select their measures.

9 I think the key is also to think
10 about we do have a usability criteria and
11 which is explicitly about is the measure in
12 use. Is it having an impact in terms of QIR
13 accountability functions?

14 So that's why in some ways I keep
15 coming back to the idea of saying it's really
16 when these measures come back up that I find
17 it more intriguing and interesting than as
18 they're up for review and you're looking at
19 the overall measure, the impact, the
20 importance, the size of acceptability, et
21 cetera, that you then include this lens rather
22 than just simply retrospectively without the

1 benefit of another committee looking at the
2 measure.

3 MS. TING: Thanks. And I don't
4 know, the usability is really good segue in
5 that I think beyond that, I would like to
6 propose that we also consider how many
7 stakeholders in the continuum health care
8 systems are impacted, you know.

9 So not to say that the ambulatory
10 or inpatient by themselves in a silo isn't
11 important, but to extend that to the extent
12 that you have a measure that impacts several
13 key stakeholders who can all report on and I
14 think it would make it more powerful. So I
15 would like us, you know, to consider that
16 possibility.

17 And then the other thing is -- had
18 a brain leakage moment. Oh, in terms of ROI
19 and how you were saying that we might not have
20 the data, I would also like to propose
21 thinking about the measure in terms of not so
22 much actionability, but in terms of turnaround

1 time.

2 So for example, if we were to look
3 at a measure like immunization or inpatient
4 readmission, you know, post procedure, those
5 tend to be a little bit more episodic.

6 And if you change the system or
7 have intervention you should be able to see
8 improvement more quickly than say trying to
9 impact hemoglobin Alc score, which is a
10 chronic disease and requires a lot of constant
11 vigilance on the part of the doctor, the
12 patient and so on. So you might not see that
13 needle move as easily.

14 And in my again practical insight
15 to a situation, a lot of times the senior
16 leadership in order to commit to
17 interventions, dollars, whatever, they want to
18 see a quick result.

19 I mean it doesn't have to be
20 return on money, but they want to see
21 improvement in quality.

22 So if we pick all these long-term

1 measurements that are going to be very hard to
2 move, you might lose kind of the power. So
3 I'd like at least to have, consider a mix of
4 some short term versus long term. That's all,
5 thank you.

6 DR. McCADE: So the white paper we
7 reviewed actually makes a point of this
8 particular aspect of it.

9 And it deals with the feasibility
10 and actionability I guess in that, and I'm
11 probably certain this wasn't done in the first
12 screening, that the impact of patient or
13 practitioners and systems that take care of
14 predominantly minority population are not
15 adversely affected by the measures that we
16 choose.

17 And I don't want to put a
18 disproportionate burden on people who just
19 happen to have very large minority practices
20 because it may not be as actionable for them
21 as it may be for other people.

22 Maybe that criteria should be

1 taken into account in your selection of the
2 700.

3 DR. MOY: This is just a practical
4 consideration, which is that you might also
5 want to look separately across these outcome
6 measures and look separately across different
7 settings, because you typically see bigger
8 disparities gaps for instance in outcomes and
9 processes and you'd bias towards outcomes then
10 if you just took a straight line kind of
11 approach.

12 And similarly you tend to see
13 bigger disparities in outpatient settings than
14 inpatient settings. So again that would be a
15 bias if you just took a straight line
16 approach.

17 MS. NISHIMI: Yes, and I agree.
18 So I think the staff probably has enough
19 guidance on the extra criteria, the types of
20 things that the steering committee would like
21 to have considered as they screen the 700-
22 plus.

1 Primarily, you know, it's like
2 we're just going to do at first, cut a
3 prevalence and quality and then we're going to
4 look to the extent to which we can assess the
5 other criteria that were discussed here.

6 And, you know, obviously the work
7 product comes back to the committee for
8 deliberation and discussion.

9 Okay, why was this one in this one
10 not this one had data this one didn't, you
11 know, I don't know, went with my gut. You
12 know, I mean there's going to be those kinds
13 of discussions but I think the staff has the
14 sense of where to proceed with that.

15 So then the next question, and I
16 think that everyone's in agreement but that we
17 need a show of hands on is, MGH proposed a
18 categorization scheme that focused on, you
19 know, looking at whether, going to Ernie's
20 point and that was a great segue, structure,
21 process and outcome measures, they divided up
22 under patient, experience or so, then they had

1 provider levels, system level, et cetera.

2 So was that categorization scheme
3 that they proposed is the committee
4 comfortable with that? Because what we would
5 then do is array the "disparities sensitive
6 set", in quotes, in that categorization scheme
7 and would allow you to see how many structure,
8 how many process, how many outcomes you had
9 where there might be gaps, et cetera.

10 DR. JACOBS: It would be useful if
11 you could point out on what page that's listed
12 so we can look at it again, please. Thank
13 you.

14 MS. McELVEEN: Sure. I was just
15 looking in it. So that's actually Section
16 3.d. on the paper and it's Page 24 in the
17 comprehensive report.

18 CO-CHAIR ANDRULIS: Sean, did you
19 have --

20 DR. O'BRIEN: Well, I didn't mean
21 to hamper the progress because this is going
22 back. I just wanted to throw out one other

1 which is looking at sample size and precision
2 issues when you're doing the screening.

3 It's not all captured in the
4 prevalence proportions that are very close and
5 is not amenable for the stratification and
6 that will be a practical issue.

7 MS. NISHIMI: Well, and I think
8 that's a practical issue that we'll get when
9 we identify the principles because that is one
10 issue, sample size.

11 CO-CHAIR ANDRULIS: Mara?

12 MS. YOUDELMAN: If you guys could
13 provide a little bit more clarity, and maybe
14 this isn't part of what you guys would do as
15 an analysis, if it's not let me know.

16 But the root of the potential
17 disparity and when something is sort of
18 patient, the patient's at the root of it, I
19 guess that was a little confusing to me.

20 And if you guys aren't going to do
21 with it then forget it, but if it is possibly
22 part of this evaluation that you guys are

1 going to do I'd like to know more.

2 DR. BETANCOURT: I think, you
3 know, we try to say, so and the easiest
4 example is asthma assessment. When is an
5 asthma assessment done? That is clearly
6 something that the provider initiates.

7 If there was an issue of
8 communication, right, so some measures are
9 more kind of patient based and those are more
10 related to communication and/or self-
11 management issues.

12 And then there were system based
13 measures which are more, you know, are systems
14 in place, interpreter services and the like.

15 So it's kind of a rough way to
16 think about these things. Some are more clear
17 cut than others, but it was our way to kind of
18 think about okay, really particularly for
19 foundation for interventions, kind of what are
20 these measures telling us about where we might
21 intervene in the future?

22 CO-CHAIR ANDRULIS: I had a

1 question that may, I think it's in here but I
2 just wanted to hear from you folks maybe
3 clarify it a little bit.

4 But when I read the section, to me
5 one of the dominant issues, challenges is
6 around care coordination, kind of connecting
7 these. While I know it seems to be implied in
8 here, I was wondering where you might see that
9 fitting in your framework context.

10 DR. WEISSMAN: There probably are
11 a bunch of care coordination measures and they
12 could fit in any one of these categories. For
13 example, patient experience is very important.

14 Assessment of care coordination,
15 it could be other things in terms of what
16 practitioners do. There could be measures
17 within the hospital. We said that there'd
18 probably be a lot of overlap.

19 I think the idea isn't, and by the
20 way I know that some people, these are not
21 additional criteria. This is just a way of
22 you've got 700, you know, if you come up with

1 a small set whether you want to call it a
2 starter set or something, you might just go
3 back to this categorization and say boy, do we
4 have some in each of these categories? And if
5 not maybe you ought to rethink it.

6 That's really I think, you know,
7 the utility of this categorization. I don't
8 think you ought to read too much into it.

9 MS. YOUDELMAN: Can I just go
10 back, because the reason I asked the question
11 and I don't know how to be delicate about this
12 so I just won't, is to me sort of having the
13 root of potential disparity being the patient
14 it's worrisome to me.

15 And I understand that there could
16 be circumstances I guess, but in general it
17 feels to me like it's almost, you know, the
18 blame the patient kind of a thing.

19 So and I'm not sure that should be
20 part of this discussion, I mean to the extent
21 that we're measuring what the provider did to
22 do the intervention to get the test done to do

1 whatever that's what we're evaluating. And I
2 guess it is somewhat process versus outcome.

3 If some of the outcome is related
4 to the patient has not complied maybe, but
5 it's just a little bit worrisome to me to I
6 guess to see it so sort of starkly in black
7 and white.

8 And Ellen's agreeing with me
9 because we just had this conversation across
10 the table and decided who was going to raise
11 it. So she can be indelicate with me too.

12 DR. BETANCOURT: Can I just say
13 though I think it's less, it's not on blame.
14 This is about potential for intervention,
15 right?

16 So if you're going to do a quality
17 improvement intervention on you see that you
18 have low numbers of asthma assessment by docs
19 and you know that you need to do some, you
20 know, report carding, auditing, feedback and
21 the like to get the rates of asthma assessment
22 up, if you see that it's something that's more

1 subject to communication then what the patient
2 based piece tells you, is that a coach or a
3 navigator might be able to help the patient
4 deal with some of the barriers to kind of
5 achieve that quality.

6 So it's less a blame and more of a
7 kind of if you were to improve here where
8 would you improve?

9 MS. YOUDELMAN: Well, then maybe
10 it's just a coding and could be called
11 communication or something else. But I think
12 it's just by calling it "patient" to me it's
13 sort of like some of it's on the provider
14 doing, some of the patient doing.

15 And so that just to me is, you
16 know, from the advocate perspective I just
17 don't like it when we sort of put on a pass.
18 It purely is semantics.

19 DR. BETANCOURT: In looking at
20 this I think the title is poor. It's not the
21 root. It's the, you could call it the
22 implementation lever or the lever for change,

1 right. I mean if it's with the position with
2 the patient, you know.

3 MS. YOUDELMAN: Then again if it's
4 a communication issue it's having the right
5 systems in place. It's not the responsibility
6 of the patient to bring the interpreter. The
7 communication services should be in place at
8 the provider level.

9 So I think it is just a framing
10 issue, but at least from I think the
11 advocate's perspective or the, you know,
12 patient whatever role I'm supposed to be
13 representing, I think it's the naming and the
14 coding more than anything.

15 MS. TING: Maybe we can call it
16 intervention audience or intervention target
17 audience. That might sound better? No?

18 MS. YOUDELMAN: No, because I
19 think if it is a bad communication then it's
20 a communications systems issue. And so it is,
21 do you have an interpreter, do you have a
22 navigator, do you have a whatever?

1 It's not really about where the --
2 I don't know. I'll let you guys figure it out
3 and wordsmith it. Those are just the concerns
4 that I'll raise.

5 MS. TING: If I may, so overall I
6 like the categories very much. The only other
7 thing that once again I must ask us to maybe
8 consider is adding another category for more
9 of the system type of metrics for the health
10 care system, you know, as a whole
11 infrastructure stuff.

12 CO-CHAIR ANDRULIS: Anyone else?

13 MS. NISHIMI: We got the
14 feedback. Mass General, MGH, you know,
15 consider what was done here perhaps think of
16 some labeling, but overall directionally, I
17 think that we're good to go on this one.

18 CO-CHAIR ANDRULIS: Okay. We have
19 another set of questions related to these
20 issues.

21 MS. McELVEEN: So again we're
22 asking for a show of hands. First question

1 is, should NQF adopt the disparities sentinel
2 measures approach?

3 MS. NISHIMI: Anyone who agrees
4 yes, if you could raise your hand.

5 MS. McELVEEN: And everyone is
6 clear on, okay. So yes, if that's the case
7 should this be applied retrospectively to the
8 entire portfolio of measures, so to the 700-
9 plus measures?

10 (Off microphone discussion)

11 MS. NISHIMI: Right. This would
12 be an additional lens as we go through.
13 Anyone, committee members who think that yes,
14 this should be an additional lens.

15 MS. YOUDELMAN: What's the result?
16 So additional lens being something that --

17 MS. NISHIMI: Is both disparities
18 sensitive and should be considered a sentinel
19 measure.

20 CO-CHAIR ANDRULIS: So the idea is
21 to review the set of 700 measures and pull out
22 those that you would consider sentinel.

1 MS. NISHIMI: So let's imagine
2 we've got all 700 measures and we checked off,
3 you know, all these that are sensitive.

4 There will probably be a subset or
5 there could be a subset if we look at through
6 the lens of ones that are also sentinel. And
7 the question is do we want to retrospectively
8 look at the portfolio or is this a notion that
9 we should consider going forward?

10 DR. BETANCOURT: I just wanted to
11 make a point of clarification, because I think
12 this should be disparities sensitive. Because
13 the review of the 700 is disparities
14 sensitivity. Sentinel is new measure
15 development.

16 CO-CHAIR ANDRULIS: It seems like
17 the language should be disparities sensitive
18 measures.

19 DR. BETANCOURT: The top one
20 should be sensitive, the bottom one is new
21 measure development which would be sentinel
22 measures.

1 CO-CHAIR ANDRULIS: The bullet
2 should read disparities sensitive measures and
3 then pull out sentinel measures from it.

4 DR. HASNAIN-WYNIA: So sentinel
5 measures are the new measures. So when we're
6 reviewing, when the NQF staff is reviewing the
7 700-plus measures, you're pulling out
8 disparities sensitive measures.

9 And we're looking at the sentinel
10 measures through a completely, well, through
11 a different lens.

12 MS. NISHIMI: Well, no, but some
13 of the sensitive measures could also be
14 sentinel, considered sentinel.

15 DR. HASNAIN-WYNIA: So sentinel,
16 can I get clarification from how you're
17 defining them, please?

18 DR. BETANCOURT: I think we were
19 thinking of sentinel as kind of new measure
20 development, yes. I mean, you know, this is
21 semantics again.

22 Sentinel means something that

1 becomes a watch post for you, right? But the
2 thinking about the first part in our
3 framework, sensitivity is a review of the 700.

4 And then sentinel is wow, you
5 know, we have disparities in pain management
6 and the ED and there's nothing like that at
7 all in the 700. That should be a disparities
8 sentinel measure that is something new that's
9 developed.

10 MS. NISHIMI: Right. And what
11 the point I am making is there may well be
12 measures that you consider to be sentinel
13 that, and there won't be very many, but there
14 may well be them within the disparities
15 sensitive set. Just because it's new doesn't
16 mean it's sentinel and vice versa.

17 DR. WEISSMAN: Just to sort of
18 beat the semantic issue into the ground,
19 sentinel has really two very distinct
20 definitions.

21 One is, you know, when we think of
22 sentinel events, those are those stand-out

1 events. That's not how we were using it here.

2 We were using sentinel in terms of
3 like the Army sentinel, you know, watching
4 over things. But as being sort of thinking
5 about the future and really thinking about
6 them as developmental in the future.

7 These are areas where, you know,
8 the literature suggests something's going on.
9 There are no measures out there, no good
10 measures out there, and so we've got to think
11 about perhaps developing or asking measure
12 developers to look at those areas.

13 You could use them either way you
14 want, but I'm just saying is that the way that
15 it's in this report, and I apologize if it's
16 not clear. It's that sort of developmental
17 issue, not sort of the stand-out sentinel
18 event type of issue. That may, you may want
19 to have different terminology.

20 MS. NISHIMI: That actually is an
21 important distinction because that's not a
22 distinction that I think we interpreted the

1 report to mean.

2 CO-CHAIR ANDRULIS: Elizabeth and
3 then Marcella and then Mary.

4 DR. JACOBS: I have a question
5 about that, because as we talked about and you
6 say in your report and looking at the
7 disparities measures. you said one way to do
8 it is to look at data we already know.

9
10 We already know that there are
11 disparities in certain things, and so as we
12 look at measures that we already know there
13 are disparities in.

14 But some of those measures, and if
15 you use that criterion impact and prevalence,
16 some of the 700 may not fall out even though
17 they could be these measures we should develop
18 and these sentinel measures. Do you see what
19 I'm saying?

20 So I think I have the same
21 confusion you do, Robyn, which is that I think
22 there is a way to look at those 700 as maybe

1 not being things that already exist that we
2 know but could potentially be measures.

3 So I just, that's where I think we
4 could develop new things and look at, take
5 that lens to look at the existing 700 too.

6 DR. NUNEZ-SMITH: So the framework
7 that I was thinking in that was slightly
8 different.

9 So I thought that we were looking
10 through the 700 for disparity sensitive that
11 we would then prioritize, so a little bit
12 different, and that any de novo measurement
13 creation would be sentinel.

14 But then following up on
15 Elizabeth's point, which was one of thoughts
16 I had earlier, which was in the first pass
17 there may be measures that don't meet our
18 criteria for, you know, delta prevalence,
19 delta quality, but we suspect might be
20 important in the future.

21 So how do we build in a way to
22 revisit those whatever we call them be it

1 disparities sensitive --

2 DR. JACOBS: The almost sentinel.

3 DR. NUNEZ-SMITH: -- or almost
4 sentinel, the quasi-sentinel, the emerging
5 sentinel.

6 MS. YOUDELMAN: Maybe it's this
7 way. So the first pass of the 700 is
8 disparities sensitive, and then you go back to
9 any one that didn't make that cut and you
10 check if they should be adapted as a sentinel
11 one or a new one becomes a sentinel one,
12 right?

13 You can't be both disparities
14 sensitive and disparities sentinel. It's an
15 either/or, but there might be some --

16 MS. NISHIMI: Well, that's the
17 question.

18 MS. YOUDELMAN: Right, but there
19 might be some, well, I guess I'm going with
20 the either/or, but I think that there might be
21 existing NQF standards that are not
22 disparities sensitive that could become a

1 sentinel.

2 MS. NISHIMI: Is the committee --
3 Mary, you had your --

4 DR. MARYLAND: And I guess what I
5 would encourage us to do in addition to
6 looking at a glossary and definition of terms
7 down the road, is to be clear that we are not
8 referring to the sentinel as we're all
9 familiar with the Joint Commission, because
10 that raises us to a different bar and everyone
11 would say of course.

12 So we either need to choose
13 different language or be so exquisitely clear
14 that we're not having this problem.

15 DR. WASHINGTON: All right, I
16 think we're just arguing semantics. If you
17 look back at the prior slide, what we voted on
18 were, were additional criteria needed.

19 And it sounds like what people are
20 saying, and I totally agree with that, is that
21 these additional criteria are needed, we just
22 should not call them sentinel.

1 But I would argue, apply this in
2 addition to the other two, and particularly
3 for the reason that Liz said that there may be
4 areas in which disparities have not been
5 assessed.

6 So overall quality measures where
7 disparities haven't been assessed, but if you
8 looked they would be there because they fit
9 into one of these categories.

10 MS. NISHIMI: Okay, so just to
11 clarify then. So we've got the 700-plus
12 measures, the staff screens them with the
13 original lens, identifies a disparities
14 sensitive subset.

15 The staff then screens those that
16 haven't been placed into that bin with the
17 four criteria that are here that are listed up
18 to see if, in fact, there are sentinel
19 measures.

20 Is that what the committee is
21 agreeing to? Does anyone object to the
22 approach that I just played out?

1 DR. O'BRIEN: Why not just screen
2 them all with all of the criteria at the same
3 time?

4 MS. NISHIMI: Well, how we
5 operationalized the recommendation I think we
6 --

7 DR. O'BRIEN: Something that I
8 thought that was in there that was important
9 was, moving forward you're looking for new
10 measures.

11 If you apply kind of the usual
12 framework that's out there or that we might
13 come up with or they may have come up with,
14 you may have missed the boat. There may be
15 areas that are not being addressed when you
16 apply the criteria that are out there, because
17 maybe they're in smaller populations or areas
18 that haven't been previously the focus of
19 performance of quality measurement.

20 But that there needs to be a
21 separate effort to take what's in the
22 literature to identify those other leftover

1 things that are being missed and not be a
2 separate effort looking at sentinel measures,
3 so they could be moving forward, sentinel
4 measures and something else.

5 DR. CHIN: Can you state it one
6 more time?

7 MS. NISHIMI: So we've agreed to
8 screening 700 measures to identify the
9 disparities sensitive set.

10 So the question is whether we
11 should take those that aren't identified as
12 disparities sensitive, but in fact may be
13 indicative of the characteristics for sentinel
14 measures, and take a pass at leaning at those.

15 Recognizing that we're going to
16 get to the question of guidance that we give
17 to future measures, that's another question.
18 Right now it's just what we do in terms of
19 sentinel measures and the existing set.

20 CO-CHAIR ANDRULIS: Ernie, then
21 William, and Ellen's leaning into her --

22 DR. MOY: This isn't about the

1 process. This is just about the criteria.

2 Another approach that people have
3 chosen are trying to perhaps ensure that there
4 are measures that are specific to specific
5 populations.

6 So maybe trying to make sure that
7 in this quote "sentinel set" there are
8 measures that are relevant to the American
9 Indian population specifically like alcohol or
10 domestic violence. That's just another
11 criteria that could be applied in addition to
12 these four.

13 DR. McCADE: So my thinking about
14 this sentinel sensitive sort of question, I
15 guess it was confusing me before and now it's
16 a little clearer, at least it was until we had
17 this discussion, is the fact that in order to
18 do the review to determine a sentinel event
19 one would have to do literature searches to
20 find out what measures or what disparities
21 exist. And then identify them as not being in
22 the 700 that exist right now.

1 And then having either an RFA or
2 whatever a quest for additional measures that
3 you submit outward to identify what measures
4 should be used.

5 Now that's how I thought that you
6 intended the sentinel event to be done. And
7 that's not a re-review of the 700 that you
8 excluded. Once you excluded them they're
9 excluded.

10 And maybe if they become important
11 later on then they may fit the criteria that
12 the data that is now available could suggest
13 that you could use an existing measure that
14 would require a re-review of the whole 700 set
15 or how many other there will be in the future.

16 But the idea of sentinel I think
17 is an entirely new sort of description of a
18 measure that exists, because there is
19 nonexistent measure and there is data
20 suggesting that there potentially should be a
21 measure.

22 CO-CHAIR ANDRULIS: Joe, do you,

1 Joe, want to say anything about?

2 DR. BETANCOURT: That's a very
3 articulate way of describing, I think, what we
4 were looking at with the exception of using
5 the term "sentinel event", because we're not
6 talking about events but that's okay. And
7 everything else is perfect.

8 CO-CHAIR ANDRULIS: Luther?

9 DR. CLARK: Yes, Robyn, quick
10 question. Do you have any sense of what these
11 numbers are likely to look like, I mean being
12 familiar with the 700?

13 MS. NISHIMI: No.

14 DR. CLARK: In terms of
15 disparities sensitive and sentinel, no?

16 MS. NISHIMI: No.

17 DR. CLARK: So it could be all or
18 --

19 MS. NISHIMI: Really I mean I'd
20 shoot from the hip if I could, but I can't
21 even get there.

22 MS. McELVEEN: So the question --

1 (Off microphone discussion)

2 MS. McELVEEN: So just to
3 reiterate, recap, we won't apply the sentinel
4 measures to the portfolio, is that right?

5 (Off microphone discussion)

6 MS. McELVEEN: Okay, so let me
7 just take a step back for a second. So the
8 paper recommends again certain categories of
9 evidence to determine disparities sensitivity.

10 And within those categories,
11 that's where they make a recommendation around
12 disparities sentinel and they also list out
13 those four sub-bullet criteria that are shown
14 on the screen?

15 PARTICIPANT: For sensitive.

16 MS. McELVEEN: For sensitive.

17 PARTICIPANT: Sensitive.

18 MS. McELVEEN: Okay, so according
19 to the paper, where no data exists on
20 disparities for a particular measure or where
21 data exists but shows no disparities, their
22 suggestion is to then apply those four sub-

1 bullets that are shown on the screen to
2 identify those measures as disparities
3 sensitive.

4 Then if a known disparity exists
5 but no quality measure exists, that's when we
6 term those measures as sentinel. Does that
7 make sense?

8 DR. CLARK: I think we're moving
9 away from the word "sentinel" because it has
10 other meanings for providers and institutions
11 than it's being used here.

12 DR. EDWARDS: So let's say that
13 you come to 35. For everything else of the
14 other 700 you are going to apply those four
15 sub-bullets, is that what you're saying? Am
16 I understanding that correctly? Was that the
17 plan?

18 MS. NISHIMI: That's what we were
19 asking the committee.

20 DR. EDWARDS: That's what I
21 understood and I vote for yes for that
22 process.

1 DR. NUNEZ-SMITH: Because my
2 understanding was that for the 700, to have
3 the staff go through. Disparities sensitive
4 is the only lens through which they would be
5 evaluating those 700, and then a whole other
6 conversation begins separate about novel
7 measures, right, for where there is, for the
8 last situation where there are data suggesting
9 a disparity but there is currently no measure.

10 So I'm just saying my
11 understanding was the staff go through once,
12 700 for disparities sensitive, not applying
13 the previously known as sentinel criteria.

14 DR. EDWARDS: But weren't you
15 asking the question of did we want you to go
16 through for the remaining, go through those
17 four sub-bullets? That's the question on the
18 table, okay, and I'm voting yes for that.

19 MS. TING: But then in addition,
20 it's possible to also still do the review of
21 brand new conditions, or emerging conditions.
22 So for disparity exists but no measure --

1 MS. NISHIMI: Yes, we're not
2 talking about going forward right now.

3 (Off microphone discussion)

4 MS. YOUDELMAN: So I've gone
5 through my 700 and I've identified 350 that
6 are disparities sensitive. All right,
7 whatever, 40. Pick your number. We know
8 there's 35 and ambulatory care, okay, so get
9 to 40. Of the remaining, can something be
10 sentinel if not sensitive? That's what I'm
11 trying to figure out.

12 Do you have to do a second lens,
13 and it's not currently care with a high degree
14 of discretion, communication sensitive,
15 lifestyle changes, outcomes rather than
16 process, but it's still a measure that if it
17 was developed slightly differently when it
18 comes up for reevaluation as opposed to from
19 scratch, it would become sentinel.

20 DR. WEISSMAN: Can I, well, Joe
21 wants to say there's another step, but I like
22 the linear thinking in trying to put things

1 into buckets and I think that makes a lot of
2 sense.

3 And here's one way to think about
4 it that you, you know, apply this the
5 prevalence and quality gap and you've
6 identified some disparities sensitive
7 measures. And then you've got a bunch of
8 others that maybe don't fit those filters.

9 But for example, it may be a
10 communication intensive measure and you might
11 consider that as a potentially, a disparities
12 sensitive measure in addition.

13 But then I think you're also
14 conflating the two tasks that NQF is trying to
15 do. One is to come up with a list of
16 disparities sensitive measures among the
17 measures that they already have, and then, you
18 know, there's new measure development and
19 where do those new measures, disparities
20 sensitive measures come from?

21 They come from this idea that
22 there are things in the literature for which

1 no measures currently exist. And those are
2 what we're calling sentinel, bad word,
3 exploratory, developmental, you know, I think
4 ought to maybe settle on a different word
5 right now.

6 And that's a different task
7 entirely I think, because when NQF recommends
8 their starter set or whatever they want to do
9 about disparities sensitive measures, there
10 are not going to be any sentinel measures in
11 there because sentinel measures don't exist.

12 It's the RFA process that William
13 mentioned. Does that help a little bit maybe?
14 And Joe, do you want to --

15 DR. BETANCOURT: I think the slide
16 that we had that was the algorithm, I think it
17 does a good job of this. Because at Step 1,
18 you know, let's say, let's dial back ten
19 years.

20 There's a measure on inhaled
21 corticosteroids for pediatric asthmatics. We
22 know there's a disparity there. That gets

1 pulled out right there. We know that's like
2 disparity measure. That's one.

3 Then the second is, well, there's
4 something that's that there's no disparities,
5 but if we look at that filter there, those
6 four points, yes, this could be something
7 that, you know, if looked at could be
8 sensitive as well. Pull that out as well.

9 And then the separate task which
10 Joel's mentioning is, you know, after you've
11 done that with the 700 then there's an RFA
12 process that's saying well, you know, the NQF
13 concludes that there are these disparities.

14 There's no measures at all, and we
15 need to go through the sausage kind of making
16 of developing those new measures that have a
17 more disparities focus to them. That's what
18 we were trying to convey.

19 CO-CHAIR ANDRULIS: Colette, is
20 your -- Romana?

21 DR. HASNAIN-WYNIA: I was actually
22 going to let this go, but then I went back.

1 So I'm actually quite confused
2 now, because I'm looking at Page 22, so help
3 me clarify, please.

4 Page 22, prior to the section 3.c,
5 the last paragraph and how disparities
6 sentinel measures are distinguished from
7 disparities sensitive measures. And as I read
8 this I am thinking that what you just proposed
9 is a different definition.

10 DR. BETANCOURT: All I can, I mean
11 if you look at what we've done at Mass
12 General, we didn't have, we know that
13 disparities, we call our disparities sentinel
14 measures right now, pain management in the
15 emergency room because by race, ethnicity
16 which we did not have any measure that we were
17 reporting to anybody or to anything.

18 And so we created, we began with a
19 chart and then began to create our own
20 internal measure for that. That's we called
21 it.

22 So we stratify our core measures,

1 HEDIS, CAHPS, you know, all that stuff because
2 number one, we think that's important.

3 We think that evidence shows us
4 that many of those are disparities sensitive,
5 and so the sentinel piece is something that
6 it's a completely new measure development.
7 That's what we were trying. And if we didn't
8 communicate it clearly, I'm trying to
9 communicate it clearly now. That's exactly
10 what we're trying to do.

11 DR. WEISSMAN: I would listen to
12 what Joe is trying to explain and --

13 DR. BETANCOURT: Yes, if it got
14 jammed up then that would, does that make
15 sense?

16 DR. HASNAIN-WYNIA: Yes, so can I
17 just, should this last paragraph then be
18 edited and rewritten to clarify?

19 DR. BETANCOURT: Sure.

20 DR. HASNAIN-WYNIA: Okay. All
21 right, because that ended up being quite
22 confusing to me because I thought that these

1 were not necessarily new measures, but were
2 measures that were specific to measuring
3 disparities.

4 Not just disparities sensitive,
5 which are general quality measures that we can
6 look at through a disparities lens, but these
7 were, that sentinel as defined here were very
8 disparities sensitive, or disparities specific
9 for helping organizations recognize potential
10 disparities.

11 DR. WEISSMAN: We apologize for --

12 DR. HASNAIN-WYNIA: Okay, all
13 right.

14 MS. YOUDELMAN: So can I just
15 build on that and clarify, because I think
16 I've now got it too, at least I hope I do.

17 So an NQF standard already is
18 collect race, ethnicity and language data.
19 And you may have another standard, a
20 hemoglobin A1b, c, whatever the heck that is,
21 H1, whatever.

22 So both of these could be

1 disparities sensitive under this framework
2 even though one is very explicit to
3 disparities, which was collect this data, and
4 one is a more generic, get your Alb -- stop
5 laughing at me. Thank you.

6 Get your Alc, but since we can
7 stratify it by race and ethnicity it's also
8 disparities sensitive.

9 So we may have different levels of
10 disparities sensitive and some that are really
11 explicit and happen that way and some that we
12 think are just sort of getting there. Do I
13 have it?

14 So we don't have a hierarchy
15 within NQF standards where are some are really
16 great and some are not. They can all be
17 disparities sensitive.

18 MS. McELVEEN: So now that we have
19 an understanding of the algorithm, let's just
20 recap. Everyone agrees we should review the
21 entire portfolio to identify them as
22 disparities sensitive, correct? Okay.

1 And everyone agrees with the
2 current definition of disparities sentinel.
3 That's a completely new measure. I'm seeing
4 some head nods.

5 DR. O'BRIEN: I'll say something
6 that I feel we're voting on this, is once you
7 take a vote on it and then the NQF staff feel
8 compelled to move forward and carry it out,
9 trickles down.

10 I feel like there's a lot of
11 confusion and I feel like I heard ideas that
12 I thought sounded great, but also the
13 overwhelming sense that there's confusion.
14 And now we're going to vote on something
15 potentially while there's still confusion, and
16 there may be everyone have a different idea in
17 their mind about what sentinel means and what
18 we're distinguishing here and distinguishing
19 there.

20 Vote on it now and now it's, your
21 stuck with it and it's going to affect the way
22 all the measures get developed moving forward.

1 And it seems to me, I'm not trying
2 to like stop any progress, but it seems like
3 you'd want to have this watertight before you
4 make a vote.

5 CO-CHAIR ANDRULIS: Well, I think
6 there's some clarity around the idea of
7 examining the 700 measures in terms of
8 sensitivity.

9 I think the term "sentinel" should
10 be removed. And you refer to "novel",
11 emerging, other, but just get rid of the word
12 "sentinel" as it's really confusing if we're
13 kind of kicking back on it. So it's novel,
14 emerging, or heretofore not identified or
15 whatever.

16 DR. JACOBS: So what we're voting
17 on now is that the 700 would be reviewed, but
18 with an eye of what we know are existing
19 quality measures for disparities and those
20 that would mean the other four criterion.

21 Okay.

22 And then in addition to those

1 we're going to think about new measures.

2 We'll just call them new measures.

3 CO-CHAIR ANDRULIS: Right, yes.

4 Are those up, or questions, Donna?

5 DR. WASHINGTON: I was just going
6 to offer similar clarification. That in
7 essence what you're saying is that the
8 definition for disparities sensitive are the
9 first two major bullets up there. One of
10 which includes the known disparities and the
11 other which includes these four criteria.

12 CO-CHAIR ANDRULIS: Yes.

13 DR. McCADE: And as part of this
14 then, the staff's work, in terms of helping us
15 to figure out what sentinel measures we should
16 take or whatever word we're going to call it,
17 novel measures we should take, are they going
18 to provide us with literature of one type or
19 are we going to use our own expertise to help
20 to develop literature?

21 I'm not sure which is the case to
22 develop the literature.

1 MS. NISHIMI: You're going to use
2 your own expertise to make recommendations to
3 staff on what areas you think would be
4 appropriate.

5 DR. O'BRIEN: Could I ask a
6 question?

7 CO-CHAIR ANDRULIS: Absolutely.

8 DR. O'BRIEN: So was your
9 intention, so disparities sensitive,
10 classifying measures as disparities sensitive
11 has been done in the past. It was done five
12 years ago apparently.

13 And I thought that this group was
14 doing something different, which was not just
15 looking at existing measures through the lens
16 of disparities, but actually saying, how do we
17 address measurement of disparities in health
18 care?

19 And that I thought it wasn't that
20 the new measures would all fall into this
21 bucket of what you were calling sentinel. It
22 was rather that moving forward there would be

1 a call for measures.

2 And that wasn't to mean that
3 everything that would be in that call for
4 measures is going to be the sentinel measures,
5 but sentinel measures was a second bucket of
6 new measures. Is there one bucket of new
7 measures or two in what you're proposing?

8 DR. WEISSMAN: So was your
9 intention, disparity sensitive classifying
10 measures, disparity sensitive has been done in
11 the past, was done five years ago apparently.

12 And I thought that this group was
13 doing different, which was not just looking at
14 existing measures through the lens of
15 disparities. But actually saying how do we
16 address measurement of disparities, in health
17 care.

18 And I thought it wasn't just the
19 new measures would all fall into this bucket
20 of what you are calling sentinel, is rather
21 that moving forward there would be a call for
22 measures.

1 And that doesn't mean that
2 everything would be in that call for measures
3 would be in the sentinel measures, the
4 sentinel measures would be a second bucket,
5 but sentinel measures was a second bucket of
6 new measures.

7 Is there one bucket of new
8 measures or two in what you're proposing?

9 DR. WEISSMAN: Well actually,
10 2008, was the report, was only about
11 ambulatory care measures. And they came up
12 with a set of principles that are very similar
13 to criteria, although the principles applied,
14 even the impact kinds of things applied.

15 They said, you know, impact on
16 minority populations, so there, there is some
17 overlap. But they came up with the
18 principles, but they came up with 35 disparity
19 sensitive ambulatory care measures.

20 Now there, not only are there a
21 ton more ambulatory measures, but, you know,
22 there are other institutions involved,

1 hospitals, nursing homes, and so on. So now
2 you've got these 723 measures.

3 So I think, what we were asked to
4 do was kind of, you know, repeat this process
5 were those principles, are they good
6 candidates for criteria? And should there be
7 new criteria considered, and so on.

8 And so what we've done, and we
9 said, well, you know, those are pretty good
10 criteria and especially prevalence, and
11 quality gap are the ones you really want to
12 focus on.

13 So as Robin was saying, you know,
14 you go through all those and the first cut for
15 disparities sensitive is prevalence and
16 quality gap, for disparity sensitive.

17 The next cut is for the ones that
18 don't make those cuts, you go and you apply
19 those other four criteria to see if any stand
20 out, I like to think of the communication
21 ones.

22 There may be ones that there's not

1 an obvious disparity gap right now but, you
2 know, you ought to think about those as being
3 disparity sensitive. And then, relying on the
4 expertise of this group, you may want to put
5 out some RFAs saying you know what, this is an
6 important area in disparities but we have no
7 quality measure among those 723, 723's not
8 enough

9 So we need some, let's develop
10 those, and then, I don't know if that answers
11 that question so far, and then a separate
12 question would be what gets done, with these
13 measures that you all identify?

14 And I think that's where the role
15 of NQF versus NCQA, you know, and who does
16 what with what, is maybe getting a little
17 conflated. You may just want to suggest a set
18 of, you know, like a starter set, that
19 somebody could use to characterize or profile
20 an organization as having equitable care.

21 Maybe you want to add some modules
22 to be sensitive to some of the geographic,

1 differences in the country, right?

2 You might want to do that, you
3 might want to make all those kinds of
4 recommendations, but you're really getting
5 into another territory there about how they're
6 actually going to be used.

7 And that's why I think, Robin,
8 kept saying we're going to list a bunch of
9 measures. It's up to other people, other
10 organizations to select which ones they want
11 but we're going to say if you want to profile
12 your organization in terms of it's equitable
13 care these are some disparity sensitive
14 measures, that you might look at. Sorry to go
15 on for so long but I don't know, does that
16 help?

17 MS. NISHIMI: Well and, but to go
18 to your point, Sean, we will move into the
19 kind of guidance that we can give
20 organizations. On the criteria or the
21 principals or the recommendations, on what
22 they should use as they identify, which of

1 those measures are better or worse for them to
2 implement. We haven't gotten to that part of
3 our --

4 DR. BETANCOURT: It might be good
5 to do a clinical example, I'm just kind of
6 trying to think through my head of a clinic
7 example.

8 Helen mentioned the end-stage
9 renal disease bucket, right? So lets just say
10 there's 20 measures in end-stage renal
11 disease. And you look at them and you say
12 well, you know, we know there are disparities
13 in end-stage renal disease.

14 So there's three of them that are
15 about, you know, some aspects of referral to
16 end-stage, to being listed for renal
17 transplantation. We know there are
18 disparities there, those three get pulled out.

19 But then there's like five others
20 where we have a suspicion that, you know, that
21 around communication issues or did the patient
22 receive information that they understood, that

1 are there but there are no disparities.

2 But those are root causes for
3 these disparities and those would be filter
4 Number 2 which is okay let's pull those out.

5 But then we know that there's a
6 lot research on trust. I'm just throwing this
7 out, mistrust and mistrust is a big issue but
8 there's nothing in that whole 35 on end-stage
9 renal disease that is related to trust, and
10 that might be some kind if sentinel measure,
11 around trust measurement, you know.

12 So I'm trying to, I'm kind of
13 trying to walk through these three buckets
14 that, you know, the new measure development is
15 something around trust, nothing there, you
16 know, some that are obvious disparities.

17 Those are takers and then there's
18 a couple that there's no disparity yet but
19 there's enough evidence to suggest that are
20 communication sensitive, disparity sensitive.

21 DR. WEISSMAN: Where Joe's coming
22 from is at MGH, we developed, or they

1 developed a, what they call a sentinel measure
2 around pain management right? So there was no
3 vetted measurement now we have this, what
4 we're calling a sentinel measurement at MGH
5 which is around pain management.

6 That terminology doesn't apply to
7 NQF because once you have that, if you have
8 that as a measure it's no longer exploratory,
9 it's no longer, you know, it's one of your
10 measures.

11 So I think that's where, you know,
12 we have to make that distinction also. In
13 terms of what an individual provider, you
14 know, that's forward thinking like MGH might
15 be, versus you know this is a national body
16 that will have vetted approved quality
17 measures.

18 So then this sentinel measure is
19 no longer sentinel it would become one of the
20 measures. It's more like the RFA process.

21 CO-CHAIR ANDRULIS: No flags up,
22 okay, we're ready for the next section then.

1 Did we vote?

2 MS. NISHIMI: I don't think we
3 need to vote on this one, I think we kind of,
4 we got it.

5 CO-CHAIR ANDRULIS: We got it.

6 MS. NISHIMI: We got the message.

7 CO-CHAIR ANDRULIS: So what we'd
8 like to do is, like I said before, the new 2
9 o'clock we'll start the mythological
10 approaches to disparity measurement.

11 That's Section 4 and since there
12 are nine sections here, we've got about 10
13 minutes each.

14 MS. NISHIMI: What we're really
15 looking for here is MGH provided some discrete
16 recommendations. You know, for instance
17 around stratification, how you should proceed
18 in terms of a reference point, et cetera, it's
19 this is the second page of your --

20 CO-CHAIR ANDRULIS: Second, it's
21 on Page 8 of your agenda.

22 MS. NISHIMI: Page 3.

1 CO-CHAIR ANDRULIS: I'm sorry page
2 8 up here, sorry Page 3 of your agenda.

3 MS. NISHIMI: Page 3 of your
4 agenda so these are the kind of principles
5 that we're looking for the group to recommend.

6 CO-CHAIR ANDRULIS: And so you'll
7 see that each of these have questions attached
8 to them, so we can, shall we start off down
9 the, unless there are some procedural points?
10 I can't believe there would be any procedural
11 points in this group.

12 MS. McELVEEN: There's also,
13 sorry, there's also a table in the full report
14 on Page 46, just so everyone has all of their
15 reference materials.

16 DR. CLARK: No, I just think there
17 might be a typo, shouldn't it be an advantaged
18 group not disadvantaged?

19 CO-CHAIR ANDRULIS: Historically
20 advantaged group, should the reference point
21 be the historically advantaged group?

22 DR. CLARK: Not disadvantaged?

1 CO-CHAIR ANDRULIS: Not
2 disadvantaged, that's right.

3 DR. CLARK: Okay.

4 CO-CHAIR ANDRULIS: So the floor's
5 open for discussion, on let's see if we can go
6 down these point by point for the time being.
7 Francis do you want to start us off?

8 DR. LU: Again a very simple or
9 simplistic question but is that entirely clear
10 to everybody, the historically advantaged
11 group?

12 CO-CHAIR ANDRULIS: Don't you
13 folks define advantaged within the paper, or
14 do you just kind of naturally assume that
15 everybody knows what advantaged is?

16 DR. WEISSMAN: Yes I think so.

17 CO-CHAIR ANDRULIS: Do you use
18 Paula Braveman?

19 DR. WEISSMAN: She did a really
20 good article a few years back on defining what
21 disparities are, and I think you know to this
22 day there are still many well respected bodies

1 that are taking, you know, the largest group
2 or the best possible group or a benchmark and
3 so on.

4 And I think these are all, you
5 know, relatively valid choices, but it just
6 seemed to us that if you're really talking
7 about equity and disparities reduction that,
8 you know, there are too many instances where
9 you get unexpected results.

10 And what you're really interested
11 in is in comparing the minority historically
12 disadvantaged population against the
13 advantaged population. And I mean, and to put
14 a label on it, it's usually the white non-
15 Hispanic group that gets chosen for that.

16 And in terms of race and ethnicity
17 and, you know, I think that was in our
18 thinking, but really based on Paula Braveman's
19 article.

20 CO-CHAIR ANDRULIS: Won't that
21 have, it seems to me that would have regional
22 implications though. For example or

1 circumstantial implications that just like,
2 you know, if you're in Appalachia, you know,
3 that's the white population would be kind of
4 a, that would be a confusing reference point
5 for advantaged group, you know.

6 So I'm just wondering whether that
7 would require, while Paula Braveman's overall
8 approach might be valuable, there might need
9 to be some further language refinement to
10 that, beyond just simply an overall statement
11 about, it's white population generally.

12 DR. WEISSMAN: Yes, I mean I think
13 that's where some of the social determinates
14 come into play. Socioeconomic status that
15 people mentioned earlier, but we're focusing
16 on the racial ethnic issue.

17 CO-CHAIR ANDRULIS: Comments?
18 Sean.

19 DR. O'BRIEN: Do you know how they do
20 it in HRQ reports and would they --

21 DR. WEISSMAN: Ernie's right there,
22 ask Ernie, don't ask --

1 DR. MOY: Yes I think, I don't. So
2 we do it more, we just compare it all to
3 whites or non-Hispanic whites or, you know,
4 high income or high education, and so it's
5 fixed across all of our comparison's and I
6 didn't know, it wasn't clear to me if that was
7 meant to be true here to or if this was going
8 to vary from measure to measure.

9 DR. WEISSMAN: I think we would
10 basically follow that recommendation, and that
11 would contrast with, I'm forgetting the other
12 example, the only other example I'd given
13 here.

14 But I think it was a CDC example
15 where you know they used a, in their
16 disparities index, their summary statistic,
17 they always took the best performing group and
18 that's a real contrast, you know, in terms of
19 what we're saying.

20 And it should be recognized, as a
21 contrast, but I would think that we would go
22 with the high, you know, in terms of SES we'd

1 go with the highest income, in term of race
2 ethnicity we'd go with the white non-Hispanics
3 as the reference group.

4 With the understanding that in
5 certain parts of the country there may be some
6 granularity that might be more appropriate.

7 CO-CHAIR ANDRULIS: Francis.

8 DR. LU: Yes, so I'm just wondering
9 would it be of benefit to align with what has
10 been done at AHRQ, so that it just makes that
11 clear with the caveats that Dennis brought up
12 about the local issues, you know, that need to
13 be taken into account.

14 But just so that, because I'm just
15 concerned that historically advantaged group
16 from a measurement point of view may be a
17 little ambiguous to some people or it's not
18 entirely clear. Whereas what Ernie mentioned
19 just before seems to be a lot clearer.

20 DR. MARYLAND: And maybe actually
21 listen to the discussion that could become one
22 of our tenets that we use standardized things

1 rather than new ones, because it tends to
2 probably unnecessarily complicate the issue.

3 CO-CHAIR ANDRULIS: Are there
4 comments on this? Next is absolute versus
5 relative disparities and favorable versus
6 adverse measures. Questions are, should both
7 absolute and relative statistics be calculated
8 and should public reporting of disparities
9 calculate statistics, using both favorable and
10 adverse events.

11 MS. WU: Well I'm just assuming, that
12 it goes without saying that there's
13 explanations included with the statistics,
14 it's not just a book of statistics that don't,
15 I don't know, who to answer, I don't know who
16 I'm directing this question to.

17 Given that there could be potentially
18 conflicting statistics that are reported out
19 there needs to be a narrative that goes along
20 with it, yes.

21 DR. WEISSMAN: Yes, and I would just,
22 just to clarify the recommendation, first of

1 all, I would alter the second sentence in the
2 sub bullet so, should, oops, let's go back.
3 They should both be, one said calculated the
4 other says reporting.

5 They should, I think the
6 recommendations they should be calculated,
7 they should both be calculated. Both relative
8 and adverse and favorable.

9 Sorry, relative and absolute and
10 favorable and adverse should be both be
11 calculated. And then I think the idea would
12 be see if they give a consistent measure.

13 And it should also be clear from that
14 little graph I showed, that at a single point
15 in time, it doesn't make that much difference
16 in terms of relative and absolute. It's over
17 time that you could come up with different
18 conclusions.

19 The Trivedi article was a classic
20 case and, Ken Keppel and I ended up writing to
21 the editor of the New England Journal of
22 Medicine because, you know, we found very

1 different conclusions by using a different set
2 of measures.

3 The favorable and adverse issue you
4 can get, that has two issues involved, one is
5 you can get a different answer over time. But
6 the other is that the reporting to the media,
7 the public perception can be very different,
8 and that's a similar but, it's a similar but
9 different issue.

10 And again, you know, you may want to
11 calculate both and see what kind of message
12 you're trying to send and if it's very
13 consistent. Then pick one because the
14 simplicity of the report is pretty important.
15 But these are complicated issues
16 unfortunately.

17 CO-CHAIR ANDRULIS: Yes.

18 MS. YOUDELMAN: Okay, so you're not
19 recommending to report absolutes, both the
20 absolute and relative statistics, so there's
21 not really a direction which one to report,
22 you're saying calculate both but not

1 recommending to report both.

2 MS. WU: See Page 30. The
3 recommendation that they put in their report
4 is close to the question. The recommendation
5 was, both absolute and relative to be
6 calculated and if it leads to conflicting
7 conclusions, both should be presented allowing
8 the reader to make their own interpretation.
9 So I think I agree with that.

10 MS. YOUDELMAN: Assuming that there's
11 some kind of narrative?

12 MS. WU: As an explanation of why
13 there's a difference, yes. So was that what
14 you wanted to know?

15 CO-CHAIR ANDRULIS: That's part of
16 the discussion, I guess the question to me
17 that comes up is if one of them shows an
18 adverse effect then, more of an adverse effect
19 so you, let's say the case where you've got,
20 you know, both lines going, both lines going
21 down, but the rate for whites is much stronger
22 than the rates for other populations.

1 Might someone say, hey we're all
2 doing well here. Versus somebody else saying,
3 hey you know this is, the race is continuing
4 but somebody's falling further behind even
5 though you know we are looking to improve to
6 this level, what's the level we're trying to
7 get to, this rate is much slower among this
8 population, the rate's much slower among this
9 population.

10 DR. WEISSMAN: I agree absolutely
11 Dennis, it's if you can, I mean even just two
12 lines, you know, on a graph, and they could
13 be, you know, very low, very high, they could
14 go in different directions, they could go at
15 different rates.

16 It's amazing how much just two lines
17 can vary so much and so there, that's where I
18 don't think there's a right answer. And I
19 think there's a context and a certain value.

20 And I think the other example I gave,
21 was the Warner article that had, you know, I
22 thought a very inflammatory title about heart

1 disease among blacks and whites in New York
2 state, saying it got much worse and in fact
3 the African American rate, had been in at a
4 fairly small level and tripled, compared to,
5 you know, an improvement compared to only a
6 doubling improvement in the whites. But the
7 disparity how as they measured it widened and
8 so they said things got worse.

9 I don't know, you know, I mean, I
10 think that's for people to decide and it is
11 somewhat of a value judgement, and it's, I
12 just think if you come up with different
13 conclusions over time as to whether things are
14 getting better or worse, you probably ought to
15 let, I think reasonable people will disagree.

16 DR. EDWARDS: I had a couple
17 questions an an intense concern. The one
18 question had to do with, are we going to have
19 any comment, or is anyone aware of anything,
20 that there's any consensus around, as to
21 what's the threshold percentage for something
22 to actually be called a disparity.

1 We wrestled with that at CIGNA, when
2 we were trying to decide what we were going to
3 go after. We never found anything so we had
4 to do our kind of best judgement and move
5 forward.

6 So that was one question I had, and
7 then I'm very concerned when we start talking
8 about leaving the reader to make their own
9 interpretation.

10 This is really complicated, look how long it
11 took us to be able to be even to tell you, hey
12 what we thought was going to be a simple task.

13 And then when I watch the news and I
14 can watch two different channels and it's
15 like, are they reporting on the same story?
16 So that makes me, I don't know what the answer
17 is, but that makes me very, very concerned
18 when you're talking about something this
19 important, and this emotionally charged, and
20 I guess I'm certainly not a statistician.

21 And I understand the whole point of
22 if you look at it this way, it looks good, if

1 looks at, it looks bad, but what's real, is
2 there really, what is real, is it better or is
3 not better?

4 And if there's a question I vote for
5 us to go with the worst case scenario
6 conclusion rather than people deciding to
7 selectively interpret it that things are
8 fabulous. When the people, you know the
9 patient at the end of the story is not any
10 better off.

11 CO-CHAIR ANDRULIS: Yes I think
12 that's what the point I was trying to get at
13 also with you, Joel, is that there is
14 disparities in context you can bring up.

15 If the trend is down for everybody,
16 that's fair game to cite that, but if the gap
17 is widening, as the trend is down, then there
18 is something else that needs to be considered
19 there.

20 And that, I think that measurement
21 should be the focus of the discussion, rather
22 than the, what could be interpreted by other

1 people locally to say, everybody's doing
2 better so, you know, it's problem solved, or
3 as being solved.

4 Now maybe it is, but I think it needs
5 another layer, I think what you want to do is
6 stimulate discussion around it to consider
7 well, what's going on, maybe it is okay, but
8 it seems to me it's a flag of some sort, may
9 not be a red flag but it's a flag of some
10 sort.

11 DR. EDWARDS: And the dollars follow,
12 that's the thing.

13 CO-CHAIR ANDRULIS: We're going to
14 Ernie and then Luther and then Marshall, and
15 then Romama, and then Donna and then, no
16 sorry, and then William. Okay so you got that
17 order Ernie, just zig zag, I think Ernie you
18 were next and then Luther, Romana then. Okay.

19 DR. MOY: A common corollary to this
20 one, because I agree that reasonable people
21 can choose to disagree, based upon these
22 findings, is to show the actual rates

1 themselves.

2 As opposed to just showing the
3 difference or the relative rate and then
4 people can look at those rates themselves and
5 have a little bit more information from which
6 to make a decision.

7 So I believe there's a corollary, to
8 not only just show difference or relative
9 rates but also to show the actually rates.

10 DR. CLARK: So I guess I'm next, I
11 have the one same concern because there is a
12 question, I think it may, it makes an
13 assumption about the sophistication and the
14 motives of the interpreter, and I think that
15 may not always be in the best interest of what
16 we're trying to do.

17 So it might be that one way to
18 approach this is to give some guidance as to
19 when relative risk and absolute risk should be
20 used.

21 Because if it was just left to the
22 discretion of the interpreter then that would

1 concern me. And I think that would create
2 some potentially problematic situations.

3 DR. CHIN: I'm wondering if it may be
4 possible to be even more proscriptive, you
5 leave a little wiggle room, for example, of
6 issue of relative and absolute as opposed to
7 say, well example present both. But I think
8 one thing that may be worthwhile for staff to
9 look at is the recent IRM report to AHRQ
10 regarding the quality in disparities
11 reports. There's one chapter that was
12 contracted out to a communications firm, where
13 they came up with, you know, very explicit
14 guidelines on, you know, basic stuff which was
15 really important.

16 So things like the titles on slides,
17 you know how you label X axis, Y axis, how you
18 label the different lines in a graph, but sort
19 of a standardization approach.

20 And it seems like these five
21 different things are all sort of that ilk,
22 where I think you've identified some really

1 key issues. But I wonder, I mean a lot of
2 comments have just been raised, there be like
3 too much leeway, you're giving.

4 In terms of like the judgement for
5 example to relative and absolute risk seems to
6 be a clear one where, the can really be
7 misused.

8 And so, unless there's reasons
9 otherwise, I would think that then both might
10 be the way to go, but I wonder if it is maybe
11 possible to have like, you know, a document
12 that essentially codifies some of these
13 recommendations and makes them feel explicit.

14 DR. HASNAIN-WYNIA: I would echo
15 that, what Marshall just said, and I think
16 also, I mean, there's just, the thing that's
17 striking to me here is that, you know, the
18 goal here is to improve quality and reduce
19 disparities.

20 And we know that if we only focus, at
21 times, on generic quality improvement, we do
22 see that the gaps remain because of the

1 differences in the relative rates of
2 improvement.

3 So I do think that, just to support
4 what Marshall has said, that it's important
5 that we show both. I think it's important to
6 show that there may be improvements but those
7 improvements may not be addressing the
8 disparity, which is our argument for
9 addressing the disparity in quality
10 improvement.

11 Because without having both sources
12 of data we'll miss one or the other side of
13 that picture. But I think that just
14 ultimately, it's this notion of, we have to be
15 able to target the disparity and where we see
16 that is when we see, you know, if we're doing
17 two groups and we see both groups improving
18 but we still see the gap remaining or getting
19 worse.

20 So I think it's an argument for
21 providing the data, that shows that you have
22 to target the disparity to address the

1 disparity.

2 DR. WEISSMAN: I mean I agree with
3 that but I just want to note that, you know,
4 you used words like gap, disparity,
5 improvement, and each one of those, when you
6 operationalize them in terms of the actual
7 rates, could mean different things to
8 different people.

9 And I think that's, you know, where
10 the, I wouldn't even call them statistical, I
11 mean, they're like math issues, right? I mean
12 that's where, you know, when you're trying to
13 look at differences in differences or
14 differences in ratios over time, and the
15 numbers just behave funny, and it depends on
16 if they're a big number or a small number.

17 I mean, Dennis, was talking about,
18 you know, a general improvement over time, but
19 the gap gets bigger. Well maybe the gap gets
20 bigger but maybe the ratio gets smaller.

21 You know, and then what does that
22 mean, do we say that the disparities improved

1 or got worse? And I think that the danger is
2 when this does move towards high stakes
3 issues, like reporting, that, you know, the
4 tendency is we want to, you know, I talk about
5 this report card that I worked on from
6 Massachusetts, we wanted to give a thumbs up
7 or a thumbs down, I mean that's what we
8 really want.

9 But sometimes maybe that you don't
10 want either of those things when the math goes
11 in different directions, you know, if you're
12 not willing to sort of give the actually
13 rates, like Ernie said.

14 Ernie, I mean, I think that's great,
15 you can give that information but I just don't
16 think the public would be able to, you know,
17 do anything with it.

18 DR. MOY: If you want the QRD
19 approach to this, is if the two absolute and
20 relative disagree we say no change.

21 DR. WEISSMAN: Yes, could do that
22 too.

1 DR. WASHINGTON: Just to reiterate,
2 I agree I think that rates should be given
3 because if the choice is left to the person
4 reporting it out, they may report absolute
5 statistics one year, relative a different
6 year. And so then it's difficult to track
7 over time, and do those calculations.

8 So I would report both the rates as
9 well as both quality and disparity, well if
10 you give the rates you kind of collect your
11 own, quality and disparity.

12 MS. McELVEEN: Sean, Marshall. Sean.

13 DR. O'BRIEN: I guess there's some
14 applications where a single number is needed
15 and, I mean, what do you do in those
16 situations, you're right, I don't know if
17 there are any interventions out there that
18 are, incentivizing hospital level improvements
19 in disparities.

20 But if there's a pay for performance
21 context you need a single number to rank a
22 provider and decide who to reward and who not

1 to reward. So if in some cases you can't
2 avoid this issue and what would you do in that
3 situation?

4 DR. WEISSMAN: Is that a rhetorical
5 question?

6 DR. O'BRIEN: Well no.

7 CO-CHAIR CORA-BRAMBLE: I didn't know
8 if you wanted an answer or if you were just
9 making a comment.

10 DR. O'BRIEN: Well, because I think
11 at some point someone's, we are going to be
12 ask to vote on this issue, do we agree with it
13 or not? But I guess in order, I think the
14 answer depends on a context and that
15 recommendation can't work out in all
16 scenarios, because there are scenarios where
17 you need one number, I think.

18 I think there's some areas where you
19 need one number, not two, so maybe I guess I'm
20 suggesting that it needs some type of
21 qualification. And then on a related
22 question, typically the NQF measures have

1 specifications.

2 And usually it's a single number, and
3 you're specifying a numerator and a
4 denominator, there are a lot of different
5 reporting issues and sometimes NQF doesn't
6 really address some of the reporting aspects,
7 but sometimes they do make recommendations
8 about, well present the number and account for
9 imprecision and other aspects of how it gets
10 reported.

11 I'm trying to get my head around what
12 will the specifications look like for the
13 types of measures we're talking about? Are we
14 talking about a set of if we have a domain
15 that has five populations, we're talking about
16 five numerators and five denominators?

17 Or are we talking about a
18 specification that actually includes, you
19 take, you take this proportion for this group,
20 and you divide it by this proportion and get
21 the ratio and would that actually that level
22 of detail be incorporated into the

1 specifications that some TAP and Steering
2 committee and eventually others will either
3 vote up or down on. I don't know what
4 everyone else had in mind for that little of
5 detail or not.

6 CO-CHAIR CORA-BRAMBLE: I don't know
7 if we're ready to get to that level of detail,
8 Joel, and I'll let you comment, you'll be the
9 author of the, you know, I don't know that
10 we're at that point. My sense is that
11 depending on what measure you chose, you know,
12 you almost got different results.

13 DR. WEISSMAN: Yes, I mean, I don't
14 think we were trying to get to that level of
15 detail, I guess we leave it up to you all to
16 figure that out.

17 I think there certainly are times
18 when you want to get to one number, especially
19 of you're going to use it in an incentive
20 program. And you could conceivably build in
21 a lot of this complexity into that, I mean, I
22 think, you know, Ernie's idea, recommendation

1 that, you know, if the absolute and relative,
2 this would be an improvement score right?

3 If you think about a pay for
4 performance program that not only looks at
5 benchmarks and thresholds, but improvement
6 over time, this is where it would come into
7 play.

8 And then you would, the question is
9 would you look at the change in the gap or the
10 change in the ratio, and if they conflict you
11 might just say, you know, no change.

12 That's one possibility, you know, the
13 same idea of making reports over time, state
14 report card and national report card, that
15 Ernie does and again if the things conflict
16 over time you might just say, you know,
17 indeterminate.

18 CO-CHAIR CORA-BRAMBLE: I think the
19 issue is when we get to, if there are
20 performance incentives, or of one is going to
21 get a differential in terms of per member, per
22 month, or something based on certain outcomes

1 then the clarity in terms of the measure is
2 going be imperative.

3 But I don't know that we can
4 determine that now, but I do agree with you
5 that there needs to be clarity.

6 MS. McELVEEN: Ernest, did you have
7 a comment?

8 CO-CHAIR CORA-BRAMBLE: Did you have
9 one?

10 CO-CHAIR ANDRULIS: Any conclusions?

11 MS. FITZGERALD: This is Dawn, if
12 possible, on the phone, can get in the queue?

13 CO-CHAIR ANDRULIS: Absolutely, Dawn,
14 you're on.

15 MS. FITZGERALD: Okay, great, I don't
16 know when to raise my hand if you can't see
17 it, so I'm just going to jump in where I feel
18 most relevant.

19 I would like to go back to the
20 original comment, that I believe it was Ernie
21 made, about a recommendation itself that, and
22 while I agree with the recommendations in

1 terms of the provision of both statistics,
2 particularly when there's conflicting
3 solutions.

4 I think a more relevant piece of
5 information is the need and desire to have the
6 actual rate displayed, the tending over time,
7 such that, regardless of what statistic is
8 used, one could make it their own calculations
9 for the alternative if possible.

10 And that also resolves the issue I
11 think where we kind of got into a discussion
12 around implementation and what one would use
13 for sort of a payment incentive program.

14 You know it's best when you're giving
15 evidence at program that you're fairly
16 transparent in that calculation. And so, you
17 know, providing the rates is the only real way
18 for, to get to true transparency and how you
19 calculate the three when the unintended
20 rational might be for using over the other.

21 CO-CHAIR ANDRULIS: So at least part
22 of the discussion is around use of the

1 absolute versus relative, is there a sense of
2 both? Is there a sense of waiting one way or
3 the other, could we put a vote to?

4 Is there general agreement on trend,
5 using trend information where possible, and
6 also, well, all information is appropriate to
7 use whether there should be a weight toward
8 that showing that kind of optimal disparity.

9 Or more direct specific significant
10 disparity should one continue to exist, as
11 featuring it not necessarily coming to the
12 conclusion about the feature.

13 Making sure that becomes a point of
14 focus, rather than being able to be, the
15 information being able to be diluted in some
16 way shape or form, than being picked off.

17 CO-CHAIR CORA-BRAMBLE: I would go on
18 record saying that I think the trend comment
19 most accurately captures I think where we want
20 to go.

21 I don't know that we have the level
22 of granularity to say that one method is

1 better than the other. I think that whatever
2 method is chosen you have to stick with it so
3 then you can determine if over time you're
4 making an impact. And that's, you know,
5 purely from sort of a quality improvement
6 perspective.

7 CO-CHAIR ANDRULIS: Great, silence is
8 assent, everybody agrees, okay.

9 (Off microphone comment)

10 CO-CHAIR ANDRULIS: Then I'll offer,
11 which do you prefer, do you prefer using trend
12 information and then highlighting, should
13 there be a disparities, a significant
14 disparities issue that's still present?

15 That that be featured in the context
16 of additional information, rather than just
17 laying out, I don't, that's option one.

18 Option two is just as Joel had
19 originally suggested, you provide the
20 information, if there's a conflict or there's
21 something that varies, that you just let it be
22 interpreted by the audiences that are using

1 the information.

2 DR. HAVRANEK: That's not an either
3 or is it? I mean you can have, you can say
4 that trend data should be shown, absolute
5 differences should be shown, and relative
6 differences should be shown.

7 CO-CHAIR ANDRULIS: Right, yes. I
8 mean they can be blended but it depends on
9 what, I guess, the guidance and interpretation
10 of the information comes into play.

11 Because I think it still opens the
12 possibility of somebody saying, well things
13 look better. But at least, you know, you
14 can't force it, but at least you can say these
15 are some of the points to consider, you know,
16 just because the trend line's down doesn't
17 necessarily mean that the disparities are
18 going --

19 DR. WEISSMAN: Dennis, can I suggest
20 that everybody just look at Page 30, while
21 they're thinking about this. And in a sense
22 that has, you know, that's got the individual

1 rates for each of the populations, it shows a
2 change over time and it displays how, you
3 know, did it get better or worse, well both.

4 So that, I mean, that really gives
5 trends, it gives rates, and it gives the
6 disparity over time, the change in disparity,
7 depending on how you define that. And so
8 everybody burns that into their head.

9 That's what we're talking about and
10 I wish I had a better recommendation, but you
11 know, and this is just one example, you know,
12 based on numbers and sort of a mid range of
13 percentages.

14 CO-CHAIR ANDRULIS: Okay, Grace and
15 then Ellen and then Marshall.

16 MS. TING: So just based on the
17 experiences at my company as well as those of
18 other health plans at the National Health
19 Plan Collaborative, we do, those of us that
20 do track health disparity matrix, do track
21 both absolute as well as relative.

22 And we do look for trends, and then

1 the other thing is that we also look for
2 favorable as well as negative comparison
3 because the favorable minority outcomes means
4 that there is no disparity among Caucasians.

5 So the best practice right now is
6 just set the best performing benchmark, and
7 then measure up to that, so I think that
8 these are very solid recommendations.

9 CO-CHAIR ANDRULIS: Ellen.

10 MS. WU: Turning to Page 30, I
11 looked at my notes here, are we talking at
12 all or noting a statistical significance,
13 because there can be a difference, but it's
14 not significant right?

15 DR. WEISSMAN: Yes, well I would ask
16 Sean, to weigh in on that. You know, that's
17 my one comment about statistical
18 significance, is that, I guess I have two
19 comments.

20 One is that it's very dependent on
21 sample size, so at AETNA or WellPoint
22 everything is statistically significant I

1 would guess. But pretty close, and so I
2 think you have to be careful with statistical
3 significance.

4 And the other thing is that some of
5 these disparities indexes, which we haven't
6 even gotten to yet, don't have well defined
7 statistical properties. And so it becomes
8 quite complicated to even calculate a
9 confidence interval which would give
10 statistical significance.

11 Again, unfortunately I don't have a
12 strong recommendation, you know, a lot of
13 this gets into judgement, discussion, context
14 and that kind of thing.

15 MS. TING: So a follow up to that,
16 so if I may comment on that based on our
17 experience do track statistical significance.
18 When we indicate those points, you know, by
19 little up and down arrows, but we also do
20 look at, in terms of general size of a
21 population.

22 So you might have an area where huge

1 statistical significance but very very few
2 people, or another area with only one or two
3 percent absolute, but a very distinct, very
4 statistically solid difference, and has a
5 very large population like the county of Los
6 Angeles.

7 And it makes more sense to then
8 focus resources to try to move the bigger
9 populations. So I think there really, you
10 measure, but then you have to be smart about
11 the data too, and sometimes you won't know
12 what conclusions to draw until you actually
13 sit there and massage it a little bit and
14 reflect on it.

15 DR. WEISSMAN: There are other
16 measures like the mean, or the standard
17 errors or the differences, as a proportion of
18 the standard errors. I'm forgetting what
19 they are but there are some other measures
20 you can look at too.

21 CO-CHAIR ANDRULIS: Norman.

22 DR. OTSUKA: It's a clinically

1 significant difference, I mean a 20 percent
2 difference in muscle strength may not be
3 clinically significant in gait for example.

4 So rather than say statistically
5 significant, I'd rather say a clinical
6 significant. And that number may be very
7 different from a statistically different
8 scenario.

9 CO-CHAIR ANDRULIS: I think the
10 order is, Ellen, and then, Edward, and then
11 Luther and then William. William do you want
12 to go first?

13 DR. MCCAIDE: Yes.

14 CO-CHAIR ANDRULIS: Go ahead.

15 DR. MCCAIDE: So I just have a
16 fundamental question about this whole
17 discussion in terms of I thought the purpose
18 of our body was to create measures, as
19 opposed to tell people who collect data how
20 to present it.

21 Maybe I'm wrong about that and you
22 can correct me if that's the case. But if we

1 do do what's suggested here in determining
2 how we should present it, there's a very
3 famous in statistics, a thing that's called
4 Anscombe's quartet. And it's presenting data
5 in a graphical fashion, that has the exactly
6 the same meaning, exactly the same standard
7 deviation.

8 And if you look at the plots that
9 come from that, they're entirely different,
10 and so I think we have to be very cautious
11 about the interpretation data and how people
12 will use it in order to make whatever point
13 they're trying to make.

14 So is it, in fact, our goal to tell
15 the end users of our metrics what they should
16 do in terms of reporting their data, that's
17 the question.

18 DR. HAVRANEK: I think we have to
19 don't we? I mean that's what the, the
20 devil's in the details here.

21 CO-CHAIR ANDRULIS: NQF, it's a
22 question of guidance for application, you

1 know, is it NQF's intention to provide, not
2 only like in this case measures, but also
3 guidance on the application of the measures,
4 interpretation of the measures.

5 DR. BURSTIN: Not very much other
6 than clearly what the directionality is of a
7 given measure being good or bad. Some
8 measures have thresholds some measures don't,
9 so not particularly.

10 CO-CHAIR CORA-BRAMBLE: If I
11 understood your question correctly, you want
12 to know what are we going to do with all
13 this, it's the so what question?

14 DR. MCCAIDE: That's it, I mean the
15 fact is we can talk about how to present the
16 data but once I own the data, it's my data
17 and I can present it in any way that I want
18 to, without having to be necessarily
19 responsible for saying whether it's absolute
20 or relative, it all depends on what trend I
21 like to show, is that not what happens when I
22 own the data?

1 DR. BURSTIN: That would be true for
2 your data, to do what ever you choose to in
3 terms of quality improvement. But if there's
4 a standardized measure that's been selected
5 for use for public reporting or in
6 performance, no you would actually need to
7 follow the standards.

8 That's actually part of the reason
9 for NGF, is to try to standardize the
10 measures across different groups into these,
11 whatever the case may be.

12 DR. MCCAIDE: Well standardized
13 measures is one thing, but standardizing the
14 way the data is actually reported is
15 potentially another thing. And so I think
16 this gets into the secondary aspect of it,
17 and that's what I was questioning, is to
18 whether we, whether that's our role.

19 This is my first NQF panel, so I
20 have no idea what you typically do, but it
21 strikes me as it's going to be hard to
22 control.

1 DR. BURSTIN: In general the display
2 of the measure is also outside of purview,
3 but I do think a lot if the same principals
4 apply that come through the measure is often
5 times what comes to the display of the
6 measure.

7 DR. HAVRANEK: Yes, when I first,
8 saw this, that graph this morning it really
9 bothered me because I wasn't sure what I
10 would do about it.

11 And so I've been thinking about it
12 a lot, and I've listened to a lot discussion
13 here and my personal conclusion is to accept
14 your proposal, that you show the trends, show
15 the relative difference and show the absolute
16 differences.

17 And the reason I feel that way are
18 two things primarily, the first is that it's
19 the most ambiguous, and on the surface that
20 seems like a bad idea.

21 I think the most ambiguous here is
22 the thing that stimulates debate the most,

1 and out of debate is going to come first,
2 attention, which is good for this. And the
3 second is it's going to come, we're going to
4 get closer to the truth if it's debated.

5 The second thing is that this is the
6 most transparent way to do things, and I
7 think that transparency is becoming a really
8 important value, and that if people feel like
9 they're not getting the full story we all
10 lose something. So you know, it's tough but
11 I think you guys are right.

12 DR. CLARK: I will say a couple
13 things, one is when you have a graph like
14 this, at least visually, unless the curves
15 are superimposed the disparity contains to
16 exist.

17 And I guess the question really goes
18 back to the issue that Colette raised earlier
19 and that is what is a clinically meaningful
20 difference.

21 And it might be helpful, if we could
22 provide either some guidance on that, the

1 fact that should be addressed, because I
2 think that's where we're caught.

3 There's statistical significance,
4 and then there's the issue of what might be
5 clinically significant or important. And I'm
6 just, if there's some way to provide guidance
7 for the provider or the individual who is
8 going to have this data, as to what to do
9 with it, rather than just leaving it to their
10 discretion it might be helpful.

11 If there's not then maybe there's
12 something we could say to them that would be
13 helpful and that they need help interpreting
14 it.

15 DR. WEISSMAN: Can I just comment?
16 So I think we have to consider here, there
17 are two issues going on here, one is looking
18 at trends over time, and seeing if things are
19 getting better or worse, that's one issue
20 that's what this graph speaks to.

21 The other which I think is important
22 is, when is a disparity, when is a difference

1 not meaningful? And that's another
2 discussion which we didn't really address in
3 here.

4 And I think even as, Norman, said,
5 you know, what is clinically significant well
6 if we had ten Normans in here I bet we would
7 have ten different answers.

8 And it's not always easy to
9 determine what's clinically significant, you
10 often have to, and it depends on, are you
11 talking about a process measure, you know, so
12 if are you talking about some sort of a
13 difference in function.

14 And in that difference in function
15 does it make a difference in, it makes a
16 difference whether that patient is an athlete
17 or whether it sits in front of a desk,
18 whether that patient's going to miss work.

19 So what's clinically significant has
20 different meanings to different people, but
21 that's not to say that it's not worthwhile
22 and, you know, you get a bunch if clinicians

1 in the room that's what they want to know.

2 So I think that's an important
3 discussion to have, so I guess I'm making two
4 points, one is that, don't conflate the
5 issues, this is trend over time, versus
6 what's meaningfully different but, and
7 they're both almost impossible questions to
8 answer clearly.

9 DR. CLARK: May I just respond
10 briefly? But I think that makes my point, I
11 mean, if the experts can't make these
12 decisions why would expect the reader or the
13 interpreter to be able to make an appropriate
14 decision as to what to do with the data?

15 DR. WEISSMAN: So in other words
16 your saying, well I think one is, I mean, I
17 think at some point there has to be a
18 judgement on whether or not, and it is a
19 judgement.

20 Let's say, take a single point in
21 time, on whether or not a disparity is
22 meaningful or not, and that is, I think that

1 does and I think you do need experts to weigh
2 in as to whether or not it's important or
3 not, clinically.

4 What does the evidence show, where's
5 the rate now, is the rate starting at a high
6 level, low level and so on. So that's at one
7 point in time you make that decision and then
8 over time you're seeing if things got better
9 or worse.

10 But then I think you would also at
11 that, you know, at the end point, you might
12 say is there still a clinically significant
13 difference or is there still a meaningful
14 difference.

15 And again, you'd have to have that
16 same discussion over time with all kinds of
17 new clinical evidence that might come into
18 play and so on.

19 So I think that you won't always
20 have an RCT, a Randomized Controlled Trial,
21 to tell you when a difference is meaningful
22 or not, but I think that you'll have to rely

1 on expert opinion and you're going to have to
2 make that.

3 And that people will have to make
4 that distinction, in the same way that we
5 make the distinction just, forget
6 disparities, just about any kind of, you
7 know, what's the optimal level of quality to
8 make, I think, that it's all dependant on
9 some research and some clinical opinion.

10 CO-CHAIR ANDRULIS: Marshall.

11 DR. CHIN: So I don't agree with,
12 Ed, in terms of a very explicit
13 recommendation that, you know, in general we
14 recommend presenting trends absolute and
15 relative data and then an example graph like
16 this, or slight modifications.

17 And it's very clear in terms of
18 explainng well, this is what we have in mind
19 or, you know, if people want to, you know,
20 step one step back, say at a minimum these
21 data are available 3:06:46 consumer report
22 cards and have a simpler display.

1 Fine but, you know, this more
2 detailed data needs to be available also.
3 But this way I think that if you don't have
4 this type of explicit description there's a
5 danger of what Bill said, that people
6 misinterpret it. You know, in the way they
7 want to do it, or present data in a way that
8 is maybe nefarious.

9 You know, Bill, was right that,
10 well, technically our charge ends at a
11 certain point, but in practice this is
12 probably at least as important in terms of
13 the actual impact, and so that if we have a
14 chance we should go ahead and make a
15 recommendation.

16 CO-CHAIR ANDRULIS: Luther or Dawn,
17 Luther is up.

18 DR. JACOBS: Sorry I have a very
19 quick question, which is, are we going to
20 make these blanket recommendations or are
21 they going to be different recommendations
22 by, as you said, how and they're somewhat

1 different depending on the measure?

2 DR. BURSTIN: I think that should be
3 whatever the group feels comfortable doing.

4 DR. JACOBS: I'm just wondering if
5 it might be measure specific, how we want to
6 actually make our recommendations. Just to
7 give more work to people.

8 DR. BURSTIN: NQF does also produce
9 for the measure to offer some guidance on
10 measure construction. And so I guess some
11 elements of this that you think are important
12 you would bring that to our Consensus
13 Standards Approval Committee to see if they
14 want to weave that into the measure of
15 construction guidance.

16 In which case, it would be something
17 that people would consider it, each time
18 they're developing a measure.

19 DR. JACOBS: Okay, thanks.

20 CO-CHAIR ANDRULIS: We have a motion
21 of sorts on the floor for approval around
22 presenting trend information where possible

1 and providing an example of that information
2 visually, much like it's presented in the
3 report. And that there be some narrative
4 related to mitigate that kind of path of
5 least resistance.

6 What I want to hear, you know, some
7 kind of narrative that describes the
8 information presented, in a way that
9 describes, use that term again.

10 Describes any trends, disparities or
11 other findings of note related to race
12 ethnicity and disparities. Some kind of
13 narrative that would accompany the
14 information rather than simply say okay
15 here's the chart, good luck, God bless, and
16 we're out of here.

17 Does that, I mean, in it's own
18 clumsy way does that kind of capture kind of
19 the three points?

20 MR. EPSTEIN: I agree, I think this
21 is almost looks like an ethics caveat in the
22 instructions, it's really a moral ethical

1 issue that we really need to come to terms
2 with. And I think it makes sense, we've done
3 this in the past, and this is a perfect time
4 do it here.

5 CO-CHAIR ANDRULIS: Colette.

6 DR. EDWARDS: And the only thing
7 that I would add is Ernie's idea, as part of
8 the explanation, that if you have the results
9 going in opposite directions you need to
10 really think long and hard about what your
11 next step's going to be. That's the big red
12 flag going off.

13 CO-CHAIR ANDRULIS: We'll ask NQF to
14 quote those words. "Thinking long and hard."
15 Do you have sufficient direction on this, or
16 do you --

17 MS. NISHIMI: Yes, I think we could
18 review the transcript and come up with
19 something that we would float by you again.
20 And obviously MGH is free to, is free to
21 alter their manuscript as they wish, but I
22 think we have the sense of where the group

1 would like NQF's position to be.

2 CO-CHAIR CORA-BRAMBLE: But you know
3 I think the message though is that the lack
4 of clarity is because it is unclear. I
5 understand that you would have to review the
6 transcript, I'm not sure you're going to find
7 the wisdom or the specificity that you're
8 looking for. I'm just saying the consensus
9 of the group, as I hear it, is that it is not
10 clear.

11 MS. NISHIMI: But we would be able
12 to convey in a concise manner the lack of
13 clarity.

14 CO-CHAIR CORA-BRAMBLE: The lack of
15 clarity? Yes, feel free.

16 CO-CHAIR ANDRULIS: Okay. We are on
17 to Bullet 3, paired comparison versus summary
18 statistics. Should a pair wise comparison
19 using historically bench group as the
20 reference point be checked to see if a
21 positive finding from the summary reflects
22 superior care received by the disadvantaged

1 group.

2 DR. HAVRANEK: Could you give us a
3 concrete example to illustrate that?

4 PARTICIPANT: Joel?

5 DR. WEISSMAN: Yes. And this is,
6 well I'll give you an example of this one and
7 then I'll make a comment also. In using the
8 BGV, Between Groups Variance, summary
9 statistic, which is the difference between
10 variance among many groups.

11 So the rationale for using a summary
12 statistic is when you have many groups and
13 you're trying to come up with a single number
14 that summarizes whether there are disparities
15 among that group.

16 And it turns out in, and a concrete
17 example is in Massachusetts when we looked at
18 this among hospitals, when we looked within a
19 hospital certain hospitals the minority
20 patients actually had better quality of care
21 than the historically advantaged, meaning
22 white non-Hispanic population.

1 And as a result that BVG statistic
2 showed a disparity and in an incentive
3 program they were not eligible for the
4 incentive payment. So to me that's a little
5 bit problematic.

6 And we pointed that out in a recent
7 article that we mention here. So that's the
8 specific recommendation that we're referring
9 to when you have a summary statistic that
10 summarizes the experience of many groups. It
11 lacks directionality and you ought to do some
12 pair wise comparisons.

13 I can also tell you that I'm not a
14 statistician, maybe Sean is more familiar,
15 there are about ten or 12 of these different
16 summary statistics. They get very
17 complicated. I had went to a presentation at
18 Academy Health where Sam Harper was talking
19 about using chaos theory to describe these
20 things.

21 It gets very ornate, very intricate
22 very quickly. And the biggest problem with

1 some of these summary statistics is they're
2 not very transparent and you don't really
3 know what's going on.

4 And so use with care, but again, I
5 wish I had a better recommendation. Because
6 if you've got three, four, five, ten groups
7 that you want to track over time, you know,
8 that can be pretty tricky.

9 This simple graph that I showed can
10 get pretty crazy. So I don't know, Ernie,
11 does HRQ use a summary statistic?

12 DR. MOY: No we don't, but Sam
13 Harper was funded by the Federal Government.
14 And we've encountered a lot of issues with
15 it. We get this push to do it but on the
16 other hand there's a lot issues dependant on
17 weighting or non-weighting.

18 And so if you don't weight it,
19 right, so each group is treated the same then
20 you get very, very small groups having as
21 much weight or importance as very, very large
22 groups.

1 And it's then a function of how many
2 groups you pick. Because the more groups you
3 pick the more possibilities for having some
4 kind of influence on the summary statistic.

5 On the other hand if you weight it
6 by population size then disparities or small
7 groups don't make any difference at all,
8 because they're so small. So you get one of
9 those possible side-effects.

10 DR. WEISSMAN: So Ernie's would
11 probably give a much better representation of
12 what some of the issues are and I think
13 that's a different and also very important
14 issue, the weighting issue.

15 CO-CHAIR ANDRULIS: Joel, in your
16 example did you or anybody else go into that
17 hospital and look at pair comparisons?

18 DR. WEISSMAN: Yes.

19 CO-CHAIR ANDRULIS: And what
20 happened when you --

21 DR. WEISSMAN: Yes, that's when we
22 found that the African-Americans were

1 receiving a better quality of care than the
2 whites. So the summary statistics showed
3 that there was a disparity.

4 But then we looked, we had white,
5 non-Hispanic, black, Hispanic and I think
6 Asian. And we looked at the individual
7 hospitals and some of those hospitals the
8 minority populations were receiving better
9 quality of care.

10 CO-CHAIR CORA-BRAMBLE: Joel, may I
11 ask what measures you were looking at?

12 DR. WEISSMAN: Those were the HQA,
13 the Hospital Quality Alliance, core measures.

14 CO-CHAIR CORA-BRAMBLE: Okay.

15 MS. WU: I don't know if I
16 completely understand this. But as far as I
17 understand of this, it seems like there are a
18 lot of cons to using summary statistics. And
19 the only reason to use it is because you're
20 aggregating small populations to make some
21 conclusion?

22 DR. WEISSMAN: I would say there

1 are, close, the overriding reason to use a
2 summary statistic is simplicity. Because if
3 you can imagine making all these pair wise
4 comparisons, you know, once against the other
5 and then over time and many years.

6 Just imagine in your head, it gets
7 pretty complicated pretty quickly. And if
8 you want, like Sean said, if you want to come
9 up with a single number this is sort of a
10 nice way to come up with a single number.

11 But there's the directionality issue
12 and then there's the other one that we didn't
13 actually address in the recommendation which
14 is the weighting issue, which is as Ernie
15 described, and I'll just summarize again just
16 very quickly.

17 So you have maybe four or five
18 different groups and one summary statistic
19 just says compare each group to the best
20 measure or to the reference group and take
21 the average of those differences.

22 Well that means that even like the

1 small group, people from Togo count just as
2 much as the white non-Hispanics, if you do it
3 that way. Or you can weight by the size of
4 the population.

5 You know there are those sorts of
6 issues that come into play as well. So they
7 have a lot of drawbacks. But I'll tell you
8 when an insurance company or health plan
9 wants to present their data on many different
10 measures it gets very complicated very
11 quickly and so it's a real tension.

12 MS. WU: But just to be clear, your
13 recommendation is to not use summary
14 statistics and use the paired comparison?

15 DR. WEISSMAN: We weren't that
16 explicit. We said you may want to use a
17 summary statistic, but if you do you better
18 do two things. One is check to make sure
19 what the direction of the disparities are.

20 And if you believe that the
21 historically advantaged population should be
22 the reference group and they're the ones that

1 are receiving the worst quality care then you
2 have to think about that before you report
3 that a disparity exists.

4 And secondly, you have to be
5 explicit about the values, which is coming
6 up, on whether you think on whether you
7 should be weighting the different population
8 groups. And you thought the absolute
9 relative issue was easy.

10 MS. WU: But it sounds like, just
11 for the sake of speeding the conversation
12 along, it feels like generally we should use
13 compared comparisons and when you are using
14 summary statistics it should be in very
15 specific cases with many guidelines.

16 DR. O'BRIEN: One difference between
17 reporting the paired comparisons compared to
18 reporting a summary measure is that the
19 paired comparisons are something that you can
20 interpret.

21 A ratio, a risk ration or a
22 difference, you know what that means.

1 There's probably no summary measure that
2 you're going to come up out there that the
3 average person will know what to do with. So
4 the end result is a number.

5 And therefore I think they're only
6 useful, if you're talking about summary
7 measures, you're really talking about
8 comparing this number that's calculated on
9 this unit, maybe it's a population or a
10 geographic area, and comparing it to another
11 unit.

12 And maybe the reason for doing it is
13 data reduction. There's just too many
14 comparisons and it's cluttered, it's too much
15 for anyone to process. You condense it into
16 a single number. But that process of
17 condensing is filled with information loss,
18 subjective decisions or just really arbitrary
19 decisions, so there's no single right way to
20 do it.

21 And I certainly don't have any
22 favorite summary measurement. So I certainly

1 agree with everything Joel has said. And I
2 think that NQF, I believe, has a position
3 paper, another framework for evaluating
4 composite measures.

5 And I think you can kind of think of
6 these summary measures as a type of composite
7 measure and use a lot of what was in that
8 prior work for this.

9 And I think that one of the
10 recommendations from the composite measure
11 committee was if you're reporting composite
12 measures also separately report the
13 individual components that went into the
14 composite measure and that seems like exactly
15 what's being recommended here.

16 CO-CHAIR ANDRULIS: It seems to me
17 also there are a couple of issues. It's not
18 just one issue. I mean take your example,
19 Joel, of that hospital. I mean, I was
20 looking at the overall disparities but there
21 are different ways, black/white disparities.

22 I mean there are populations of

1 sufficient end in many places that you can do
2 these kind of comparisons against the
3 advantaged group on a chart. But for others,
4 the smaller groups, then you run into small
5 ends and you run into a variation.

6 And then you've got, you know, there
7 are layers of complexity here in terms of how
8 you approach the use of summary statistics
9 versus the disaggregation to a point. Where
10 there's potential benefit of looking between
11 group comparisons.

12 So I think one of the charges for us
13 is to consider when you're going to use the
14 summary versus when to use paired and that
15 there's no clear, again there may not be
16 clarity on when to apply them.

17 You may want to apply them all, to
18 the extent you can within large groups. And
19 then when you get the smaller groups they may
20 have to go into summary statistics of some
21 sort. Or use, you referred to the methods
22 that you talked about before, where you

1 aggregate, roll up. Ellen? Elizabeth.

2 DR. JACOBS: I had a question about
3 often these sorts of summary statistics are
4 used by NQF? Is it a common thing? I mean
5 maybe this isn't used that often, it's kind
6 of a moot point.

7 DR. BURSTIN: We actually do,
8 increasingly, have had a lot of composite
9 measures, but to me that's really more where
10 the direction has been rather than a summary
11 statistic, per se.

12 DR. JACOBS: So I wonder if given
13 the concerns people have about it and it's
14 not normally used whether it's something we
15 need to continue to discuss?

16 DR. CHIN: Although what may happen
17 is that if we end up coming up with a long
18 list of disparity measures then it may become
19 more of an issue in terms of simplicity.

20 CO-CHAIR ANDRULIS: Colette.

21 CO-CHAIR CORA-BRAMBLE: One comment.
22 The one thing I would argue from a

1 clinician's perspective is the more complex
2 we make this I feel the less likely that
3 people are going to use it in a very tangible
4 way.

5 So although some of it is almost an
6 academic exercise. I want to make sure we
7 keep it relevant to those, to the end user.
8 And the end users they're not going to be
9 statisticians, that's just not going to be
10 the case.

11 CO-CHAIR ANDRULIS: So. Motion for
12 lack of clarity?

13 (Laughter)

14 (Off microphone discussion.)

15 MS. NISHIMI: I didn't hear a silver
16 bullet so let's take a break.

17 CO-CHAIR ANDRULIS: Okay. Ten
18 minute break.

19 (WHEREUPON, the meeting went of the
20 record at 3:25 p.m. and went back on
21 the record at 3:45 p.m.)

22 CO-CHAIR ANDRULIS: Okay. We've

1 beaten a few horses so let's go on to the
2 next one. Normative judgements about
3 disparities measures. We're in Section 4.f
4 on Page 33. Section 4.f, is that it?

5 PARTICIPANT: It's actually 4.e.

6 CO-CHAIR ANDRULIS: That's right.
7 4.e right above 4.f, conveniently. And the
8 question is, what can be recommended to
9 minimize normative judgements in the
10 selection of disparity sensitive measures?
11 Can objective criteria be identified in this
12 regard?

13 And what we were discussing up here
14 among NQF staff and the co-chairs is that I
15 think what we're going to try to do here is
16 instead of getting closure around
17 recommendations per se, that the focus should
18 really be on discussion of these points and
19 trying to give staff direction for, then
20 formulating, at least drafting a direction
21 that we can then consider later, if I've
22 captured that correctly.

1 MS. NISHIMI: Right, if something is
2 clearly bright line and we can move on with a
3 recommendation then I think we should go for
4 it. But the last couple we've kind of gone
5 round and round and round and beat the horse
6 really dead. And I only want to beat things
7 sort of dead so we can move on that way.

8 CO-CHAIR ANDRULIS: Yes and we've
9 had a reconsideration. We're probably going
10 to aim to close at 5:00, so it's been a long
11 day. So we'll get as far as we can by about
12 5 o'clock. Okay. So Section 4.f, you have
13 any opening comments, Joel, on 4.f?

14 DR. WEISSMAN: Not really. Although
15 I'm wondering if the question should be to
16 minimize normative judgements or if NQF ought
17 to make the normative judgement in its
18 recommendation. That would be the only
19 comment I'd have.

20 And I would just, I guess as an
21 example, I think an example helps. Talking
22 about this Healthy People 2010 Report. And

1 the normative judgement that came into play
2 there was around the summary index, which had
3 a bunch of different groups.

4 And they decided that they would
5 compare each subgroup to a reference group
6 and that each one would count equally. And
7 that was the normative judgement they made.

8 They made a judgement saying each
9 group had equal importance, no matter how
10 small the group was.

11 And you can make a different
12 judgement saying you should weight those
13 contributions by the population size, that's
14 an example of a normative judgement. The
15 other one has to do with should the least
16 healthy group make the most progress?

17 There are a number of different
18 things and the statistic that you chose can
19 influence the kind of progress that you show.

20 And so I think this, you know, we
21 were just doing our job in terms of raising
22 these issues so that you'd at least consider

1 them.

2 CO-CHAIR ANDRULIS: This is actually
3 an interesting variable and a measure that we
4 looked at before. Where it may again require
5 further drilling down on the measure and
6 their reference point for normative may be up
7 for consideration as well.

8 Because in the did looking at
9 changes in the 100 largest cities and suburbs
10 over time we picked low birth weight as a
11 variable to examine. And we found that the
12 trend at the point, this is back in the 90s
13 to the 2000 Census Data, that there had
14 actually been an improvement in some of the
15 minority populations while there had been an
16 increase in the majority of the advantaged
17 population, so called.

18 And it wasn't until you looked
19 further into the information about low birth
20 weight that you realized that it had to do
21 with multiple births that were occurring
22 among women who were holding off on having

1 children later in life.

2 And that it was happening in places
3 statistically that you hadn't thought of,
4 like the suburbs that you were seeing this up
5 tick.

6 So it's just kind of a number
7 reference point that the issues around
8 normative and perspective on numbers may need
9 to be taken into consideration at another
10 level as you try to identify those reference
11 points for these populations. Comments on
12 normative judgement? Sean.

13 DR. O'BRIEN: I think it's just
14 important just to recognize that they are
15 implicit in the way we measure things and the
16 way we weight things. But I think this is
17 posed as a problem and I'm not sure it's a
18 problem.

19 CO-CHAIR ANDRULIS: Elizabeth.

20 DR. JACOBS: I just want to say I
21 agree with Joel. I mean I think we should
22 make recommendations about what's normative.

1 I mean that's what measuring disparities is
2 all about, right, don't harm in making
3 normative judgements. I mean, what's good?

4 CO-CHAIR ANDRULIS: So on the table,
5 questions about normative judgements.
6 Luther.

7 DR. CLARK: I was just going to say
8 I agree and maybe just a statement that a
9 reference should be made to minimize
10 normative judgements.

11 DR. JACOBS: To what?

12 DR. CLARK: Excuse me?

13 DR. JACOBS: Reference to what,
14 sorry.

15 DR. CLARK: The bias that is
16 apparent in --

17 DR. JACOBS: I'm sorry.

18 CO-CHAIR ANDRULIS: So a reference
19 to minimize normative judgements. Then what?

20 DR. CLARK: Inherent bias.

21 CO-CHAIR ANDRULIS: Inherent bias.
22 Other tents?

1 MS. NISHIMI: Anyone have any other
2 comments on this issue?

3 CO-CHAIR ANDRULIS: Ellen.

4 MS. WU: I don't understand it.
5 Sorry, it might be too late in the day for
6 me. Or effects of sugar. Can you define
7 normative judgement?

8 DR. WEISSMAN: Yes. Value
9 judgement. What do you think is important?

10 MS. WU: It's just so -- so then
11 from what I understood Liz was saying, it's
12 what the standard should be, like what the
13 improvement should try to achieve?

14 CO-CHAIR ANDRULIS: Joel, mic.

15 DR. WEISSMAN: You could think of a
16 number of different things. That's a good
17 question, what do you want to achieve? Do
18 you want to bring minority populations up to
19 the white population or do you want everybody
20 to improve? That's one value judgement,
21 that's a value choice.

22 Do you think that all groups should

1 be equal or are you more concerned about the
2 more populous minority populations, and focus
3 on them.

4 I don't know, people help me out.
5 I think if you just continue to ask that
6 question, what do you want to achieve, that's
7 a value judgement, normative judgement.

8 Probably should use values. And it
9 turns out that the measure that you select,
10 or the statistic that you select, can often,
11 some people think reflects the value
12 judgements of the people who select that
13 statistic.

14 The CDC believes that all groups
15 should contribute equally, no matter their
16 size. And so in Healthy People 2010, they
17 report a summary statistic where each group
18 contributes equally. That's a value
19 judgement. I'm just raising the issue.

20 CO-CHAIR CORA-BRAMBLE: Can we agree
21 that it just needs to be mentioned, and you
22 know, just move on?

1 (Off microphone discussion.)

2 CO-CHAIR ANDRULIS: Ellen, you have
3 a look of puzzlement still.

4 MS. WU: Well I guess that's fine
5 and it feels like there's a lot of these
6 questions that we're theoretically talking
7 about now which is going to happen really in
8 the future when we look at the measures and
9 the data, that, and I know we're trying to
10 set some parameters or guidelines.

11 But that for particularly for this
12 instance it feels like when there's a red
13 flag in particular it maybe should get vetted
14 somewhere.

15 If there's a decision to be made one
16 over the other value in what statistic or
17 what goal we're trying to achieve. It feels
18 like there should be some process for input.

19 MS. NISHIMI: I think what my sense
20 here is though we can't identify a single
21 rule set.

22 MS. WU: No, right. For me I guess

1 it's more about process. That when this
2 issue comes up there's a process for input.
3 That there's a tangible example on the table.
4 Does anybody understand?

5 CO-CHAIR CORA-BRAMBLE: I'm just
6 trying to make it relevant, but not more
7 complex than it needs to be. And I think in
8 this case merely mentioning it should be
9 sufficient.

10 However, if there is a situation
11 comes up then we should discuss and vet in
12 more detail we certainly can do that.

13 But right now, at this juncture, I
14 really think that just including it is
15 sufficient. And I just want to make sure the
16 group is in agreement with that.

17 DR. WEISSMAN: Yes, I just think one
18 more comment. I think it's important as
19 you're making these recommendations to just
20 kind of keep this in back of your head and
21 think of how it's going to play in Peoria.

22 You know, I always tell my kids we

1 live in the People's Republic of Cambridge,
2 it's kind of like this room, you know, we're
3 pretty well a liberal group.

4 But imagine if there was some sort
5 of incentive program that encouraged the
6 reduction of disparities. In order to do
7 that some health plan actually made the
8 quality of care for white non-Hispanics
9 worse.

10 You know I think in certain parts of
11 the country that wouldn't play so well. And
12 in thinking about how -- And it's not just
13 about measures. I mean we talk a lot about
14 measure selection, but we're going beyond
15 measure selection here I think.

16 We're talking about reporting of
17 differences in measures and that's where the
18 rubber hits the road. And people are talking
19 about it.

20 This is a very charged area and so
21 I just think that just maybe I agree with
22 Robin, we just say it's an issue and move on.

1 CO-CHAIR ANDRULIS: Okay. It's an
2 issue an we're moving on. Okay. We're going
3 to skip down to the second last bullet to
4 risk adjustment and stratification and that's
5 Section 4.i.i., that's on Page 39 and 40 and
6 41.

7 And with the recommendation that
8 performance reports stratified by
9 race/ethnicity should not be risk adjusted by
10 SES or other contributory factors. Instead
11 should be further stratified at the date of
12 permit.

13 Question to us, as you can read for
14 the stratification, are race, ethnicity,
15 primary language be performed when there is
16 sufficient data to do so, should NQF review
17 its policy of risk adjustment, vis a vis,
18 inclusion of race/ethnicity?

19 MS. YOUDELMAN: Where are you
20 reading that?

21 CO-CHAIR ANDRULIS: It's in the list
22 on the agenda. It's on Page 4 of the Agenda.

1 I think -- Elizabeth.

2 DR. JACOBS: I have a question.

3 Isn't this redundant with what we talked
4 about before? Because we said we're going to
5 pull out these measures on which we're going
6 to ask people to stratify on race/ethnicity,
7 right? I guess I need clarification on the
8 question. Because didn't we already discuss
9 that?

10 CO-CHAIR ANDRULIS: I guess I was
11 wondering about this too. It seemed like we
12 had a discussion saying as much as you can
13 you want to do that. Want to stratify by
14 race, ethnicity and language. So is this a
15 kind of revisiting or it has another angle?

16 DR. BURSTIN: I think this has
17 another angle, mainly in terms of risk
18 adjustments for outcomes.

19 So one of the issues that comes up
20 repeatedly is outcome measures come to us
21 especially society's other developers, they
22 have done their risk adjustment models, and

1 lo and behold the race/ethnicity is
2 significant, as is gender as maybe SES.

3 They put them in their models, they
4 bring them to us and we have traditionally
5 said no race, ethnicity or language in our
6 models. That we want to be able to stratify
7 by those results. We don't want them buried
8 in the risk adjustment model.

9 This comes up, I was just downtown
10 at a CMS meeting, I was just asked this
11 question 15 minutes ago. So this is an issue
12 that comes up constantly when you're using
13 measures ultimately to pay for performance.

14 So we, I think, feel like we're on
15 solid ground but we thought it was an
16 important issue because it keeps coming up
17 and the stakes have gotten higher and higher,
18 especially on readmission measures for
19 example with a penalty coming in 2014.

20 There continue to be concerns people
21 have raised that some hospitals in very poor
22 communities, for example, may not do well.

1 But again it's more philosophical, but we
2 thought it was important to bring it to this
3 group.

4 DR. WEISSMAN: And just as a further
5 level of clarity. To simplify, there are two
6 levels of the risk adjustment question.

7 So first of all it should be clear,
8 now we're talking about an overall measure of
9 quality and should you risk adjust for race
10 and ethnicity when there's an assumption that
11 certain minority patients have poor quality
12 of care. Are you going to be disadvantaging
13 the provider.

14 The second level of that is when
15 you're identifying disparities should you
16 then risk adjust for socioeconomic status and
17 other social determinates. That's a separate
18 question. But you could adjust for all of
19 those at the same time.

20 You know, Sean could probably tell
21 you, you could throw everything into the
22 model at once but there are different

1 conceptual issues for each of those two
2 questions. Good luck.

3 CO-CHAIR ANDRULIS: Mara.

4 MS. YOUDELMAN: I'm confused this
5 time. Can you just explain what NQF's
6 current policy is? I've missed that, I'm
7 sorry I don't quite get it.

8 DR. BURSTIN: I probably need more
9 decongestant. So the current policy is that
10 NQF precludes the inclusion, that doesn't
11 allow the inclusion of race, ethnicity and
12 gender in risk models. That indicates to
13 developers if they measure that those results
14 should be stratified rather than risk
15 adjusted for those variables.

16 Exactly for the reason of being
17 concerned of masking disparities. But
18 because it keeps coming up we thought it'd be
19 worth raising again.

20 And recently the conversation has
21 shifted a bit to say, okay, not race and
22 ethnicity and language, let's SES. Let's

1 talk income, let's talk geography, let's talk
2 some of those other issues, which are other
3 considerations.

4 MS. YOUDELMAN: I guess I'm confused
5 about you're saying it's not masked, it's
6 stratified by. And maybe that's because I
7 just don't --

8 DR. BURSTIN: If it's in the model
9 you can't stratify on it. You've adjusted
10 those differences.

11 MS. YOUDELMAN: Okay. Got it.

12 DR. WEISSMAN: Helen, maybe ought to
13 give an example of how it would be used.
14 Stratified versus risk adjusted.

15 MS. YOUDELMAN: So what you're
16 telling me is -- If you tell me I can't
17 stratify by it later, I'm fine. I agree.

18 DR. BURSTIN: What does any risk
19 model you can't stratify by it? So basically
20 like some of the STS measures for example,
21 cardiac surgery measures, have traditionally
22 in the past, I don't think they do anymore,

1 included, race and ethnicity.

2 And so once it's in the model you
3 can't afterwards, post hoc, show how we'd
4 stratify it. Sean, you've thought a lot
5 about this, do you want to --

6 DR. O'BRIEN: Yes, I'll try. I
7 think my personal position is it really
8 depends on the particular purpose of what
9 you're trying to do with the measure and
10 there's not a one-size answer, it's really
11 context dependent.

12 Traditionally when you think about
13 risk adjustment conceptually the question
14 you're asking is what the outcomes of this
15 particular unit looks like if the case mix
16 was not the actual case mix that they treated
17 but some other case mix.

18 And standardizing that case mix, and
19 conceptually is to take factors that are
20 present at the point of where the care
21 episode begins and then you might generalize
22 that to really think, really present before

1 the time of accountability beings, really,
2 maybe.

3 And try to, don't adjust for factors
4 that were within the control of the
5 healthcare provider or things that you might
6 want accountability for. Because then you
7 would adjust away he differences that you're
8 trying to measure.

9 But I think it gets, I can imagine
10 exceptions to the rule with scenarios where,
11 in gender for example, it is a reasonable
12 question to ask, you really think there's
13 something about women, or there's differences
14 that aren't explained by any quality
15 difference.

16 Anything that providers are doing in
17 cardiac surgery sewing around the aorta that
18 the size of the anatomy can really make a
19 difference in terms of how long the operation
20 takes and things like --

21 So there may be just inherent
22 differences. And I'm probably saying things

1 that are wrong and there's probably people
2 that would disagree on that.

3 But I think there is a perspective
4 that says well, if you're trying to estimate
5 this standardized difference then, sure, you
6 could have gender in the model.

7 And that you'd still want to address
8 these gender disparity issues. But maybe
9 that's a separate topic. And I think, for
10 me, the risk is we have normative goals,
11 policy goals and separate just kind of being
12 able to define and estimate some quantity.

13 If your goal was to estimate some
14 quantity you want to define that quantity and
15 estimate it the right way and you don't want
16 to leave something out of your analysis that
17 makes you not estimate what you think you're
18 estimating. So that's where I'll stop.

19 CO-CHAIR ANDRULIS: Edward.

20 DR. HAVRANEK: I guess I would sort
21 of echo a lot of what you said. So you may
22 think that you're on solid ground.

1 But I think the ground is not as
2 solid as you think it is because of the
3 biologic and genetic issues that are
4 inherent, certainly in gender and to some
5 extent in race and ethnicity.

6 So the issue with cardiac surgery
7 for instance is that women have higher
8 mortality than men. Is that a disparity or
9 is it related, as Sean was saying, on the
10 fact that surgery takes longer, is
11 technically more difficult because of body
12 size?

13 I would maintain that it's the
14 latter, that there is a real biologic
15 difference there and by failing to adjust for
16 gender you have created a disparity perhaps,
17 where none exists.

18 You know I can make similar
19 arguments with regard to race in congestive
20 heart failure, in atrial fibrillation.
21 Markedly different in African Americans.

22 And so the prognosis would

1 essentially be better so you would expect on
2 a genetic or biologic basis there to be
3 better outcomes in African Americans.

4 So equal outcomes is actually a
5 disparity in that case. Failing to adjust
6 gives you a false impression of reality. And
7 then the socioeconomic, failing to adjust for
8 socioeconomic position.

9 I think you've probably heard a lot
10 of push-back that for some measures things
11 like 30 day readmission, failing to adjust
12 for socioeconomic position, puts safety net
13 hospitals, hospitals that disproportionately
14 care for the disadvantaged, puts them at a
15 distinct disadvantage with regard to pay for
16 performance and public reporting and all that
17 stuff.

18 Because the determinates are social
19 and are things that hospitals don't have
20 control over.

21 And so I think that it might be
22 reasonable to continue the policy as you've

1 had it but there needs to be come caveat or
2 some statement that goes along with that that
3 said we are aware of the problems that this
4 approach is creating.

5 CO-CHAIR ANDRULIS: Okay. Marshall
6 and then Elizabeth. Elizabeth then Marshall.

7 DR. JACOBS: I'm going to disagree.
8 Respectfully disagree with that position. I
9 used to work at a disparity institution, Cook
10 County Hospital in Chicago, and really we
11 should design our care to serve our patients
12 who happen to be quite disadvantaged.

13 I think it's important to note I
14 really appreciated in the report that there
15 was a discussion about really not adjusting
16 for these things because then you don't see
17 the racial disparity.

18 I mean unfortunately these things
19 co-occur, race and lower socioeconomic status
20 in this country and higher socioeconomic
21 status. And it's our job as healthcare
22 providers and institutions to actually

1 address them.

2 And if we take away those
3 differences by adjusting for things it
4 doesn't give us an opportunity to recognize
5 what are the determinates of what happened
6 and then to address them.

7 And I would also argue that, and
8 Bill's really the expert on this, but this
9 issue of genes versus what happens in the
10 environment, I mean it's not clear that
11 people are necessarily going to be more
12 disadvantaged biologically, that that
13 distresses in their lives because they happen
14 to be a different race and puts at a
15 disadvantage biologically.

16 So I think it's really hard to sort
17 that out but really it's our job, even if it
18 were genetic we would still have to do a
19 better job of taking care of them because
20 they're at higher risk and we should know
21 that.

22 DR. HAVRANEK: Can I respond to

1 that? I think maybe you misunderstood where
2 I was coming from here. I think that the
3 issue with, and you know I agree that systems
4 should be designed to take care of the
5 patients that they are responsible for taking
6 care of.

7 However, the current systems are
8 such that, you know, with pay for performance
9 and things like that, that if you penalize
10 people whose care is more expensive to
11 provide to the patients that they are
12 responsible for, you've done them a great
13 disservice. You've hit them twice
14 essentially.

15 And I agree that if you're at Cook
16 County in Chicago that taking care of a group
17 of patients who has trouble getting to
18 appointments because they can't afford cab
19 fare, et cetera, et cetera, et cetera,
20 providing them with that stuff is going to
21 provide them with better care.

22 But it's more expensive and it's

1 more resource intense. And the current
2 system potentially takes resources away
3 rather than adds resources in.

4 DR. CHIN: Yes, I think that
5 actually what Ed and Liz and what you all
6 wrote in the paper are all consistent. I
7 think it's actually one of the elegant things
8 about paper in that it shows us though that
9 we can't just stop at doing the descriptive
10 work with the disparity measurement.

11 But because of the implications
12 downstream we have to include all of this
13 implementation issue in the recommendations.

14 In other words we're saying don't
15 stratify but don't include race/ethnicity
16 within the risk adjustment models because we
17 want to stratify so we can see if there were
18 differences.

19 Ed's bringing up the point that well
20 it could lead to problematic issues like with
21 this hospital compare program to the
22 readmissions where you're penalizing the Cook

1 County's of the world.

2 And that was like another part of
3 the paper where it's saying well you know we
4 need to build into the implementation
5 safeguards to prevent the rich getting richer
6 problem.

7 So whether there are additional QI
8 resources for the Cook County's or the idea
9 about like risk adjusted reimbursement. So
10 in other words once we start down this
11 pathway we have to do it all in terms of, I
12 think we do have to do it all, in terms of
13 going through these different scenarios for
14 implementation.

15 Otherwise you put down one thing
16 which helps disparities but that can hurt
17 unless they're all addressed. So I think we
18 are on a pathway that I think we need to do,
19 of being comprehensive, just like the paper
20 was comprehensive.

21 CO-CHAIR ANDRULIS: Other comments?
22 Elizabeth. Colette. I'm sorry, Colette, you

1 were in the queue.

2 DR. JACOBS: Actually I think
3 Marshall covered it. I was just going to say
4 that we do, on Page 8, really lays out a lot
5 of lovely options I think and it's not
6 immediately clear to me.

7 I'm just trying to think it through.
8 If you embed it first, if you kind of do it
9 after the fact, is it always going to be the
10 case that you won't pick something up.

11 But the bigger statement really is
12 related to what Marshall said in that we
13 definitely need to pay attention to this one
14 because it is going to be tied to dollars.
15 And that's only going to be more and more and
16 more true.

17 So we just have to safeguard against
18 whichever choice we make so that the people
19 who are taking care of the patients with the
20 issue, get the resources that they need to do
21 that.

22 CO-CHAIR ANDRULIS: Elizabeth, back

1 to you.

2 DR. JACOBS: I just want to say at
3 the risk of Dennis asking earlier if I'm
4 always the troublemaker and I said yes, I
5 have a reputation in my family, and I may
6 have it here.

7 But I just want to actually put
8 forth that, I mean this is a really tough
9 word to use but this is how racism gets
10 institutionalized.

11 If we have a system that penalizes
12 people, or organizations, for taking care of
13 people who happen to be disadvantaged and
14 then what we do is then, so we can't measure
15 it, we can't measure that they're
16 disadvantaged, we can't measure the ways in
17 which they experience disparities because it
18 would penalize these organizations.

19 That's the way this all stays quiet.
20 And so I loved, I thought the ideas that you
21 put forth, Joel, in your report were really
22 creative about actually paying people more

1 to take care of poor people instead of
2 disadvantaging them.

3 And in fact maybe paying them even
4 more if you lower the risk of that
5 institution. Could you imagine if there were
6 a certain risk at Cook County and then you
7 pay them more to take care of them and then
8 you also give them some incentive to bring it
9 down.

10 I mean there's different ways you
11 could do it. I think there's other models to
12 figure out how we can. I just don't want the
13 current models, which I think unfortunately
14 ask us not to ask these hard questions and
15 keep us from asking these hard questions or
16 measuring these things. Not to let them
17 determine what we do.

18 CO-CHAIR ANDRULIS: But I think what
19 that does though, your comments also are kind
20 of a bookend to, or work well with Marshall's
21 comment, in the sense that there is an
22 obligation then to make sure that this is

1 explicated in some way, shape or form.

2 Because if it were done, as Denice
3 has said, kind of in this academic abstract
4 of well, let's present these data in this way
5 and let's not stratify on these indicators.
6 Then those points could very well get lost in
7 the discussion.

8 Therefore it kind of comes back to
9 your point, Marshall, that if you're going to
10 start down this path that you've got to
11 follow through. You've got to also
12 acknowledge these other elements. You know,
13 Joel's good presentation notwithstanding on
14 this point.

15 I think we may need to explicate on
16 these other indicators to make sure that
17 we're not institutionalizing racism further,
18 but at the same time we're not dooming these
19 providers to insufficient dollars and
20 insufficient support to actually carry out
21 these more complex social determinates and
22 particularly related challenges.

1 MS. CUELLAR: I have a comment and
2 then if Colette could bring Page 8 up I made
3 a note here. I just want to reiterate, I
4 believe someone had brought it up earlier.

5 One of the things I feel is missing
6 in here, again, is we're talking about the
7 provider from the standpoint of the
8 practitioner and the patient.

9 But I think if some standards are
10 going to be met by health systems we really
11 have to think in the global standpoint,
12 something that affects system-wide.

13 I'm thinking of the person who takes
14 care of the patient 24/7, the nurses the
15 respiratory therapists and it has to come
16 from above.

17 So we really have to think more
18 globally, much like joint commission does or
19 CMS does, that we really have to set some
20 standards that are more or less implied
21 institutional wide.

22 And I think a lot of onus has been

1 put on the practitioner and the patient. But
2 I really think to really drill down to where
3 it's a win-win for everyone it has to hit
4 everyone in that organization.

5 And the only way I think we can do
6 that is to hit, that's what I feel is missing
7 here is some systemwide, because it's the
8 health systems that are ultimately going to
9 start the continuum of care that goes on to
10 the outpatient basis. And throughout this I
11 felt some of those measures were missing.

12 CO-CHAIR ANDRULIS: And in some ways
13 that point kind of reflects back to our
14 discussion. And since what comes to mind for
15 me also is, in the case of safety net
16 organizations, one thing is primary care or
17 emergency care. The other is specialty care,
18 getting referrals.

19 And if you're going to penalize some
20 of the safety net institutions for not having
21 access to specialty care that has to be done,
22 it shouldn't be done and it has to be taken

1 into consideration in the context of the
2 systemic viewpoint rather than just simply
3 the practitioner or the --

4 CO-CHAIR CORA-BRAMBLE: I do have a
5 comment. This issue of risk adjustment, it
6 is very nuanced and I do agree with your
7 recommendations, Joel, in the paper, which
8 you suggested in the terms of risk adjustment
9 of payment to the providers which you had
10 mentioned, I totally agree with that.

11 My concern is that if we say we
12 don't want to risk adjust, but yet this
13 group, this body, has no impact on the
14 policies as it relates to paying providers,
15 we're basically saying don't do this but
16 we're penalized as providers on the other end
17 if we take care of large groups of minority
18 patients.

19 And there is no differential in
20 terms of our payment, so we're saying don't
21 do this but we really have no authority over
22 what providers are going to get. So I'm

1 trying to put a very realistic framework.

2 You know in my group here in D.C. we
3 are the largest provider of primary care
4 services for underserved kids. So most of 90
5 plus percent of our kids are Medicaid
6 enrolled children and 90 percent are
7 minorities.

8 So the risk adjustment issue is a
9 very real question for us. Particularly when
10 we're not getting any added payments for all
11 the extra effort that it takes to raise the
12 bar for these kids.

13 So I'm just trying to be very
14 realistic about what it means to say don't
15 risk adjust, but on the other hand we don't
16 have any say so in terms of how much we can
17 pay for.

18 DR. WEISSMAN: Yes, I mean I guess
19 my answer, and I think I'm sort of aligned
20 with Liz's comments, but with real
21 appreciation for what's going on. And I
22 think perhaps one of the values, one of the

1 values of what this group can do is to really
2 highlight this issue. And, I mean, people
3 are talking about it, but I don't think
4 they're giving it enough attention.

5 And, you know there is some lip
6 service, I think mentioned here there was,
7 you know, a letter from the AHA or something,
8 but this, you know, I mean people have to
9 change policies to address this.

10 That they have to realize that
11 providers with disadvantaged populations have
12 a tougher time and have poorer outcomes. And
13 we don't want to institutionalize those
14 outcomes and excuse them, right?

15 We want everybody, we want equitable
16 care for everybody, but on the other hand,
17 it's a resource issue and, you know, don't
18 get me started, I think if anything the
19 country's going in the wrong direction. I
20 mean, you know, the gap between Medicaid and
21 commercial insurance is getting bigger.
22 That's exactly the wrong direction.

1 So I think to the extent that this
2 group can really come out strongly about what
3 the, you know, why risk adjustment is fair
4 and yet dangerous.

5 CO-CHAIR CORA-BRAMBLE: I think it's
6 important, I mean, that clear example is when
7 we're caring for language minority kids,
8 limiting this proficient you know populations
9 that, yes we care for them.

10 But the issue is, in many places,
11 there's no reimbursement for interpretive
12 services. So yes, care for them, don't risk
13 adjust, but incur the expense, you know, that
14 is our reality.

15 CO-CHAIR ANDRULIS: Mary, then
16 Ernie.

17 DR. MARYLAND: So if we accomplish
18 nothing more than what the conversation has
19 been in the last five minutes, we've done a
20 really good job. Now if we could figure out
21 how to make the policy follow our discussion.

22 And I think, the other piece is that

1 we have to be aware that, the more we fail to
2 talk about the tough stuff, the more that we
3 allow it to perpetuate.

4 As an example in many areas of
5 Chicago, and I also trained at Cook County,
6 we no longer have a trauma system, because
7 we've allowed people to withdraw from it
8 because it's expensive.

9 And so Lourdes and I, at the
10 beginning of this meeting, were talking about
11 the outcome that related to Congresswoman
12 Gifford's being so wonderful. Because of her
13 immediate access and sustained access to
14 excellent care.

15 And so if there's a way for us to
16 impact the availability, accessability and
17 mandate to require excellent care, we have
18 more than done our jobs.

19 DR. MOY: Yes I would be hesitant to
20 put out a message that don't risk adjust
21 period, but I do think that the way it's
22 written is that instead of risk adjustment

1 you ought to stratify.

2 So stratify and then you can
3 compare, apples with apples, you can compare
4 each box, black with blacks or low income
5 blacks with low income blacks. And then it's
6 a fair comparison. I think that's a good
7 message, to stratify instead of risk
8 adjustment.

9 DR. WEISSMAN: Although I'd like to
10 point out that that also has the danger of
11 institutionalizing poor care. I mean, in
12 spite of our recommendation you know people
13 shouldn't think that that solves the problem,
14 right?

15 Because imagine, I mean, I think you
16 have to take the next step and understand how
17 this could be used. And so if it's used for
18 incentive payments, stratification in some
19 ways does nothing different because you say
20 oh, okay your poor black populations are
21 treated just as well, or poorly, as everybody
22 else is, so you're okay.

1 But at least it's more transparent
2 and so there are, that's where the other
3 policy recommendations that I made come into
4 play. That we have to recognize, we have to
5 be fair to the providers, but recognize that
6 we need different policies to eliminate those
7 disparities.

8 CO-CHAIR CORA-BRAMBLE: I would say
9 that in terms of the entire report, whatever
10 we submit, this is probably one of the most
11 critical areas. And that it needs to be very
12 nuanced, it needs to demonstrate to the
13 public that we understand the issues, and
14 that we've looked at it from every
15 perspective.

16 CO-CHAIR ANDRULIS: And that they're
17 tied, which you can't do one without the
18 other.

19 I think we're going to Edward, and
20 then Marshall and then to Sean and Grace.

21 DR. HAVRANEK: Just wanted to maybe
22 clarify or propose that I think what I've

1 been trying to say is that, not that you
2 should change the policy, in other words, I
3 don't think that risk adjustment for age,
4 gender, socioeconomic status, I don't think
5 it's a bad thing.

6 And I think a policy should
7 continue, I'm just asking that the policy
8 come with an asterisk. That says that there
9 are times where failing to adjust for these
10 things actually is having the opposite effect
11 to what we intend.

12 And I also agree with, Joel, that
13 stratifying doesn't solve the problem with
14 risk adjustment. So that's why I'm asking
15 for an asterisk.

16 CO-CHAIR CORA-BRAMBLE: And I would
17 add that it should be more than an asterisk,
18 I think it's an important enough issue that
19 it needs to be in the body of whatever, you
20 know, not in a footnote, not as, you know, as
21 a sort of sidebar thing, but imbedded in
22 whatever in whatever it is we're doing.

1 DR. HAVRANEK: In bold, or italics?

2 CO-CHAIR CORA-BRAMBLE: Yes, there
3 you go.

4 DR. BURSTIN: Actually to add to
5 that, NQF does a sub criteria and
6 specifically unintended consequences. So
7 maybe it's important to actually tie these
8 two together, stay grounded to the criteria
9 as logical approach, which I like.

10 DR. CHIN: Lourdes point about teams
11 and care coordination, just reminded me that,
12 one thing that we should explicitly do, you
13 know, in the next half day or so is to
14 include, to some discussion about the
15 measures that are going to be the ones that
16 aren't on the radar screen now, but are
17 important given the current organizational
18 forums on the pike.

19 ACO's, medical homes, bundle
20 payment, so things like the care coordination
21 multi disciplinary teams and so this whole
22 variety of different measures that, I know

1 that the wider point, which I was trying to
2 think about, but for disparities, maybe they
3 were particularly relevant in terms of some
4 institute care coordination. Continuum of
5 care, team best care, things that you
6 mentioned, Lourdes.

7 CO-CHAIR ANDRULIS: That's also,
8 it's an interesting point in the Affordable
9 Care Act because, that the community health
10 centers are funded but the speciality care,
11 other links, regarding the benefit about
12 upping funding for community health centers
13 is not described in explicate, in great
14 details and some medical homes and medical
15 care but there's not that, there's that
16 missing link.

17 Sean and then Grace, and Mara.
18 Sean, go ahead.

19 DR. O'BRIEN: So I think my main
20 concern about the risk adjustment position
21 isn't that I don't agree with it 90 something
22 percent of the time. It's that I, when you

1 put in a policy we don't know who's, we
2 haven't really had time to think through, and
3 innumerate all the different possible
4 implications, follow it to its logical
5 conclusions.

6 Is there any scenario in which it
7 may lead to a kind of counter intuitive
8 result, have the opposite effect of what
9 we're trying to accomplish.

10 And my suspicion is, yes, if we had
11 enough time to think about it there would be
12 enough counter examples, problems that we
13 might want to revisit.

14 I think one way I think about
15 quality measurement is one thing measurement
16 does is it, you can think about it from the
17 perspective of what type of behavior and
18 change are you trying to effect.

19 And that from the perspective of
20 incentivizing and changing there is a real
21 rational for not adjusting, not trying to
22 institutionalize, racism.

1 But another thing you're doing when
2 you're doing quality measurement is you're
3 trying to measure something. And there may
4 be research applications, there may be
5 internal quality improvement, where you look
6 at a result and you're trying to attach a
7 particular interpretation with it.

8 You're trying to see how your
9 results have changed over time. And if you
10 look at your results, and it could be a
11 situation where an institution has really put
12 an intervention in place, to improve their
13 quality on some disparity group.

14 And within that group, that
15 population quality has really, really
16 improved but the composition, the population
17 composition of that institution changed over
18 time.

19 And so now it looks like they are
20 doing worse and that would just be kind of a
21 mistake, it's kind of the data fooled them
22 because they didn't analyze it in a way that

1 accounted for the change in their population
2 concentration over time.

3 So I think an alternative approach
4 instead of saying let's tackle this issue up
5 front, at the phase of risk adjustment, is to
6 go to other creative, out of the, you know,
7 out of the box, or ways of addressing these
8 issues that I think that probably everyone in
9 the room agrees should be addressed and are
10 important.

11 But just try to figure out are there
12 other ways of doing it that don't meet the
13 challenges of interpretation when you're
14 using these measures to estimate quantities
15 that may have a lot of different purposes.

16 MS. TING: Thanks, and I think that
17 too, Denice's point, it's just very
18 important, that we make it very clear, that
19 we've been thoughtful about it and that we
20 lay out the various implications.

21 Because you know in rolling out this
22 kind of data to physician groups, from a

1 health plan, was actually provided dashboards
2 where we didn't risk adjust per se, but we
3 showed their performance compared to that of
4 their regions, and how their, the physicians
5 panel compared to the panels or the patient
6 populations in their regions.

7 And we found, you know, that there
8 are high performing groups was health
9 disparities and there are low performing
10 groups with no disparities and when we
11 vetting it with the physician leadership of
12 various groups for feedback, what the actual
13 response we got back, was this is very
14 valuably information.

15 It helps us think through what we
16 can implement, but because the claims data
17 may be flawed or the way we bill may differ
18 from group to group, before you think of
19 compensating that space on this type of
20 stuff, you know, we really need to resolve
21 some of these data feed issues and these
22 adjustment issues.

1 So I think that that's a point that
2 we will need to make, is that we can't even
3 think about these different payment models
4 until some of these issues get resolved.

5 But I can say that even without risk
6 adjustments the physician groups seem to
7 really appreciate this as a quality
8 improvement tool. So we shouldn't let the
9 risk adjustment or not discussion stop us.

10 MS. YOUDELMAN: My first is an
11 apology that I'm going probably have to run
12 before the conversation ends today to make it
13 to daycare in time.

14 But the question that I have is on
15 this stratification should be performed when
16 there is sufficient data to do so. Who
17 defines sufficient? Does NQF, does someone
18 get to decide? How does that come into play?

19 Because that's, I think a big if,
20 depending on how it's defined or how it's,
21 and how much leeway there is.

22 CO-CHAIR ANDRULIS: Joel did you

1 have an idea behind that or are you punting
2 that?

3 DR. WEISSMAN: I'm not punting it
4 entirely, my foot's getting tired from
5 punting a lot of these issues.

6 You might think of the, there are
7 statistical tests you can do to determine
8 what would be a statistically stable number.

9 For example in the premiere
10 demonstration, you know, the rule of thumb is
11 30. You know 30, units of quality, and so
12 there's probably is some minimum level at
13 which you would feel comfortable stratifying
14 the data by. And other than then you would
15 want to roll up into larger categories.

16 DR. BURSTIN: Not on that point, but
17 actually going back to Sean's comment, about
18 are there other creative ways? I also just
19 wonder if there is an option to consider
20 balancing measures here?

21 Where, you know, if you're really
22 concerned about the change of the case mix of

1 a population is there an opportunity to
2 couple an outcome measure where there's not
3 risk adjustment for these factors, with an
4 examination of the population or something
5 like that.

6 CO-CHAIR CORA-BRAMBLE: Give us an
7 example.

8 DR. BURSTIN: People have talked
9 about this, for example, when concerns have
10 been about certain providers not taking on
11 the highest risk patients, in addition to
12 looking at the outcomes of care for those
13 highest risk conditions, you also look at the
14 case mix overall, to see if as, you know, are
15 they funneling down to the lowest risk
16 patients to get their better outcomes.

17 So it's kind of just a balance on
18 case mix, just, I don't know, Joel had any
19 thinking about that. It was just sort of
20 struck me when Sean said, think creatively
21 here, about other options.

22 DR. WEISSMAN: We've certainly

1 thought about risk selection as a way to
2 improve you quality scores, and I think
3 that's why taking in Marshall's comments, and
4 others, is that we're sort of often thinking
5 about just one type of policy, without trying
6 to think of the bigger picture.

7 And that it's why in other, that I
8 think that if you just try one policy lever
9 then it's always going to be able to be
10 gamed.

11 And that the best approach is to use
12 a number of different policy levers to get at
13 the different outcomes that you want to
14 achieve. So I mean that's more of a policy
15 question than a measurement question but
16 that's how I would look at things.

17 CO-CHAIR ANDRULIS: Okay it's
18 settled again, right?

19 MS. NISHIMI: Can I just ask Helen,
20 is this getting the conversation where you
21 need it to be in terms of the NQF policy?

22 DR. BURSTIN: Yes.

1 CO-CHAIR ANDRULIS: I think we're
2 going to, we feel that there's a certain
3 brain drain here. So, it's been a very
4 intensive day, and I think it's time to
5 perhaps move on to other things, so I think
6 we're going to call it here and pick it up
7 probably with this minor point of
8 consideration of socioeconomic and other
9 demographic variables tomorrow.

10 And that's one of the reasons I
11 think we're going to call it now. And what
12 time are we convening tomorrow, what's your
13 preferred time? Eight?

14 DR. BURSTIN: 6:00 to 7:30 for
15 breakfast, 8:00 for starting.

16 CO-CHAIR ANDRULIS: 7:30, breakfast,
17 8:00 starting, Starting at 8:00, breakfast
18 at 7:30, so bon appetit.

19 (Whereupon, this meeting concluded
20 at 4:35 p.m.)
21
22

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In the matter of: Healthcare Disparities

Before: NQF

Date: 07-11-11

Place: Washington, DC

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