NATIONAL QUALITY FORUM

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HEALTHCARE DISPARITIES AND CULTURAL COMPETENCY CONSENSUS STANDARDS

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MEETING OF THE STEERING COMMITTEE

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TUESDAY, JULY 12, 2011

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The Steering Committee met at the Liaison Hotel, 415 New Jersey Avenue, NW, Washington, D.C., at 8:00 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:
HELEN BURSTIN
HEIDI BOSSLEY

KRISTIN CHANDLER
NICOLE McELVEEN
ELISA MUNTHALI
ROBYN NISHMIMI

ALSO PRESENT:

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

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

(8:08 a.m.)

MS. MCELVEEN: Good morning. Good morning, everyone. Welcome back for our second day of fun. No, I hope everyone had a good night. We are going to provide a recap of our accomplishments from yesterday, as well as our agenda and goals, what we want to achieve for our day today.

First, for those folks who do have computers, again we have internet access available. Just let me know if you need that login information, and I pulled that up on the screen. You do have a few additional handouts that we've made copies of at your stations, and we will address those later on in the afternoon.

So, to provide a recap of what we accomplished yesterday, if you recall, we had four specific goals outlined for this meeting as a whole, and we did accomplish quite a bit yesterday. It was a very robust discussion.

We did receive your recommendations on the criteria for identifying disparity-sensitive measures. We did go through that. We also talked about how NQF should apply that criteria to our portfolio of measures.

In addition, we did cover some of the methodological considerations for measuring disparities. We will continue that conversation today, and we also received some recommendations around broader implications for measuring disparities, and some of those conversation pieces came out a little bit in the morning as we began to discuss the paper, as well as in the afternoon.

So, more specifically, I'd like to quickly review some of the key recommendations that we feel were captured through the conversations of our meeting yesterday. If the Committee does not agree or if you have something additional to add, now is the time to let us know, but these are the outputs and

recommendations that we feel were captured.

So, in terms of guidelines for identifying disparity sensitive measures, it was clear that the Committee agreed that prevalence and quality gap certainly were important to distinguish when it came to identifying disparity sensitive measures.

In addition, impact was very strongly advised and recommended from the group and really on different levels, so talking about impact across stakeholders, impact on the community level, impact on the minority populations that you're addressing.

We felt that the Committee was agreeable to the concept of disparity sentinel measures. However, the term sentinel was not something that you wanted to utilize, and you suggested a different term.

We will explore another term to use, but the concept of sentinel measures, meaning if there is no -- if the data exists for disparities measures, however, there is no

measure to address it, developing a new measure is what we -- is what we're calling -- currently calling sentinel measures, but, again, we will re-term that.

Finally, when we talked about reference points, the Committee agreed that the reference group should be the historically advantaged group while considering other geographical variations to that.

So, these key recommendations that I've just stated, is everyone sort of in agreement with that? Are there any -- yes, go ahead.

DR. NUNEZ-SMITH: Good morning. So, I just wanted to make sure for the disparity sensitive measures that what was also included were those other four criteria that we talked -- and that didn't -- this was a different --

MS. MCELVEEN: Ease and feasibility, is that --

DR. NUNEZ-SMITH: No, in the areas

where disparities, where the data --

MS. MCELVEEN: For the sentinel measures.

DR. NUNEZ-SMITH: No, I was looking up to try to find the list of four, and Joel could probably help me.

MS. MCELVEEN: Yes.

DR. NUNEZ-SMITH: But when it's sort of -- when there is a lot of care discretion --

MS. MCELVEEN: Yes.

DR. NUNEZ-SMITH: When there's discretion by provider, when it's lifestyle, behavior, so all of those criteria.

MS. MCELVEEN: Yes. Okay. Did we have another question or comment? Okay.

DR. WASHINGTON: I just wanted to make the same point.

DR. MARYLAND: And just in the area of looking at the historically advantaged group, I think there was a recommendation around looking at terminology with that

advantaged group language, as well.

MS. MCELVEEN: Okay. So, moving on, we did talk about our absolute and relative disparities, and the key recommendation was to calculate not only absolute and relative but also trends, keeping in mind providing some sort of narrative for the end user to really understand what method was used and how that relates to the data that they're reviewing.

Paired comparisons and summary statistics, there was no preference made for one versus the other, but, again, considerations were mentioned for implementation and how that would relate to the end user.

Around normative judgments, key recommendation that it must be acknowledged, and then, finally, for risk adjustments and stratification, we heard from the group that it's important to outline the implications for the end user as it relates to risk adjustment

and stratification. Also, we felt that the Committee generally agreed with the current NQF policy but noted consideration should be given where exceptions might be important.

Any comments or questions? Sure. Donna?

DR. WASHINGTON: Yes. My interpretation of the discussion regarding the paired comparisons versus summary statistics is that we discussed many of the disadvantages of summary statistics.

I thought we agreed with the comment or the recommendation as written, which is should a pairwise comparison using a historically advantaged group as a reference point be checked to see if a positive finding from the summary statistics reflects superior care received by the disadvantaged group.

To me, that doesn't imply lack of preference. In, fact, it's guidance for how to use a summary statistic.

DR. HAVRANEK: Just with regard to

the last point there, the last three words, instead of "might be important," my sense was that what we were really concerned about is might have unintended consequences. So I would hope that you'd be a little bit less vague, a little bit more specific.

MS. MCELVEEN: And, I'm sorry, what was that relating to for the --

DR. HAVRANEK: The last three words on that slide.

MS. MCELVEEN: Okay.

DR. WASHINGTON: In fact, we actually didn't explicitly address the choice of pairwise versus summary. The recommendation, I think, in the report was for a pairwise statistics whenever possible, which I would agree with.

MS. MCELVEEN: We didn't feel the group had reached a conclusion, but if that is what you're proposing and the group agrees, you know --

CO-CHAIR CORA-BRAMBLE: So, Donna,

I hear that as your proposal, but I'd like to hear from the rest. I don't know if there's alignment here in terms of whether that was what the agreement was or whether it's something that's being recommended. Ellen?

MS. WU: I agree with that.

CO-CHAIR CORA-BRAMBLE: Okay. Anybody else? Does anyone have a counter-argument regarding that? Okay, we'll consider that an agreement. Thank you.

MS. MCELVEEN: So, our work for today, of course, we'll continue to review those methodological issues, that list that we had started yesterday. We'd also like to then go through and discuss Section 5 of the paper, which talks about priorities and options for quality improvement in public reporting.

Finally, we would like to receive some recommendations from the Committee on framing the Call for Measures around disparities. Again, we've provided some handouts to help you think through that

process, and we also have a few slides, as well.

Lastly, continue to explore NQF's approach for measuring disparities prospectively. I know we did go through a few concepts around that yesterday, and you all did provide some recommendations, so I'd just like to revisit that and make sure there weren't any additional recommendations to add.

Any questions or additional comments before we get started?

CO-CHAIR CORA-BRAMBLE: Okay, so, big team, my goal is to take us all to the finish line, to do it all in a timely way, so let's rock-and-roll. Okay, so the three areas that we still have to discuss in terms of methodologic issues are interaction effects, sample size consideration, and consideration of socioeconomic and other demographic variables.

Joel, I would ask you to at least frame each of those sections. Perhaps we can

start with interaction effects, if you could just give us a few sentences to sort of tee up the discussion.

DR. WEISSMAN: Sure. The best way I can describe the interaction effect is that when we show disparities I point to the Schulman article that was pretty famous and got a lot of press, published about ten years ago.

The media picked up on disparities as being, you know, blacks and women have less access to cardiac care when, in fact, if you showed the four groups separately, black women, black men, and so on, it was white women, white men, and black males all received equitable care. It was only black females that were disadvantaged, and, you know, it's an important point to make.

So that is a classic interaction effect where the effect of one variable depends on the level of the other, and so, you know, you can always go a little crazy with

this and look in a lot of -- and you get into a sample size effect when you start reducing the sample size and having more categories, but at least probably race-ethnicity by gender ought to be looked at just to see what's going on.

CO-CHAIR CORA-BRAMBLE: Thank you, Joel. So let's start the discussion among the group members. Any counter-argument, or are we in agreement with the recommendation? Do we concur? Donna?

DR. WASHINGTON: I concur with that, but I would also suggest considering examining race-ethnicity by income.

CO-CHAIR CORA-BRAMBLE: Okay. Other comments? Yes, Francis?

DR. LU: I'd add age, as well.

CO-CHAIR CORA-BRAMBLE: Okay, so we'd add those other variables, income, age. Anything else? Yes?

DR. MOY: Urban/rural effects.

CO-CHAIR CORA-BRAMBLE: Okay.

Just use a mic. Yes, so what he said -- Dr. Moy said --

DR. MOY: Urban/rural.

CO-CHAIR CORA-BRAMBLE: Yes, urban and rural effects. That is correct. Was that a comment or not? Just wanted to make sure that I acknowledge you. Anyone else?

DR. HAVRANEK: We just have to be really careful with interaction just because the statistical issues for one is that the number of individuals and events that you need to pick up any kind of meaningful signal, you know, they're hard enough when we're looking at just race and ethnicity, but when you start looking at interactions it becomes very complicated.

I think also there's a -- we have to also be careful that there's not a lot known about how these issues interact in terms of some of the things like stereotyping and bias and stuff like that.

I mean, to some extent they work

together. To some extent, they counteract each other. So I'm really -- I mean, I think we have to raise the issue that it's important, but trying to deal with it explicitly I think is clearly a problem.

CO-CHAIR CORA-BRAMBLE: So, just to make sure that we -- that we understand the comment is that you don't necessarily disagree, but you think we have to be really careful.

DR. HAVRANEK: I think we have to be really -- no, I think it's important to raise the issue that there are interactions among these things, but in terms of turning these into quality measures, things that get measured, I don't think we're ready for -- those things are ready to be rolled out.

CO-CHAIR CORA-BRAMBLE: Okay. Acknowledged. Yes, Romana?

DR. HASNAIN-WYNIA: So, this is not so much about interaction, but I don't think we ever discussed stratifying by payer,

and I think we should. The AHRQ report does, doesn't it, a little bit?

DR. HAVRANEK: Could you expand on that? I don't understand what you --

CO-CHAIR CORA-BRAMBLE: Does it go beyond private and public, or is it --

DR. HASNAIN-WYNIA: Medicaid --

CO-CHAIR CORA-BRAMBLE: So commercial versus Medicaid.

DR. HASNAIN-WYNIA: Right.

CO-CHAIR CORA-BRAMBLE: So it's sort of a different measure --

DR. HASNAIN-WYNIA: Measure.

CO-CHAIR CORA-BRAMBLE: -- as it relates to socioeconomic.

DR. HASNAIN-WYNIA: Right, because we keep talking about socioeconomic. We talk about income. We don't always have those data. We do have payer, at least at the provider level, so --

CO-CHAIR CORA-BRAMBLE: Unless they're uninsured.

DR. HASNAIN-WYNIA: Right.

DR. HAVRANEK: You're talking about using Medicaid as a proxy for low income? Is that what you're proposing?

DR. HASNAIN-WYNIA: In some ways, yes.

CO-CHAIR CORA-BRAMBLE: Yes.

DR. HAVRANEK: Okay.

DR. HASNAIN-WYNIA: Where we have that, right.

CO-CHAIR CORA-BRAMBLE: Because of availability of data.

MS. WU: Can I -- can we add highest level of education? I think you guys do that when it's available. I'm sure it's not going to be available most times.

DR. WEISSMAN: I mean, that gets into the discussion about adjusting for socioeconomic status.

CO-CHAIR CORA-BRAMBLE: Correct. Correct, but I'm not hearing explicit disagreement in terms of the interaction

effects recommendation. All right. Romana, do you have another comment or not? Okay, please go ahead. I can't see everybody's name, so forgive me if I just point to you.

DR. OTSUKA: I agree, but the only other effect is perhaps generational. The longer you're here, the more generations, the effect of your race or ethnicity wears off, so to speak, I think. Culturation, exactly.

DR. WEISSMAN: Something that might help in the discussion about when you look at a lot of interaction effects and you get into very small groupings is that it's -- following on the point that Edward was making was that you may not have enough to use as a public reporting measure, but it might be something that you want to look at, the provider may want to look at internally as a QI.

So, in other words, in this same Schulman example, you know, a particular provider may not have enough cases to reliably

report that black women were disadvantaged, but internally they can sort of act on that information, because when you're only a provider, even a few cases are enough to kind of change practice.

So that may be part of the recommendation that consider these interaction effects. If big enough, report them. If not, you may want to consider them for internal QI purposes.

CO-CHAIR CORA-BRAMBLE: Okay. Thank you. Does anyone else have a comment? Mara, yes?

MS. YOUDELMAN: And language, which just wasn't brought up, but stratifying by language.

CO-CHAIR CORA-BRAMBLE: Okay. Anything else? Anything else about that? Marshall?

DR. CHIN: So, there's Joel's report, and then, I guess, there are the recommendations. Could you tell us a little

bit about the difference in the sense that the scenario where it's going to be a long list of variables, which I think are important to stratify by? There needs to be some type of paragraph about sort of why or how you use or -- a lot of this is based upon what is the purpose for what you're doing.

CO-CHAIR CORA-BRAMBLE: Right.

DR. CHIN: So, Joel's paper can do that. Is that also in the brief of recommendations that's going to come out, also?

CO-CHAIR CORA-BRAMBLE: You know, I would think that we would have to have some sort of companion document to explain some of this. I don't think it needs to be, clearly, as extensive and thorough as Joel's paper, but, you know, if I were not a part of this Committee and these -- and I was reading the recommendations, I would need a little bit of help in terms of, you know, to contextualize, particularly certain sections that there was

a lot of debate and discussion. Yes, Romana?

DR. HASNAIN-WYNIA: So, this again strays a little bit from measurement, but it builds -- just Marshall's comment covered this, though. In terms of NQF's charge, NQF in my mind has always been kind of the measure endorser, right, kind of the Good Housekeeping seal of approval.

But we seem to be going beyond that charge here, and I just -- I just want to explicitly acknowledge that. In some ways, I mean, we're going beyond just the measure development endorsement, rather, and into almost what I would consider standard setting.

CO-CHAIR CORA-BRAMBLE: I agree with you. Some of these issues are so complex and laden with multiple levels of, you know, layers of issue. I'm not sure that we can do just the standards in complete isolation, but I acknowledge what you're saying.

DR. BURSTIN: I think also the role of NQF has evolved, and I think it's not

just about endorsing standards at this point, so, you know, to actually look at the mission statement now it's building consensus on national priorities and goals. Disparities certainly fits there for performance improvement and working in partnership to achieve them, so I think there is a lot of opportunity here.

Again, as Marshall pointed out yesterday, there's ways for us both to help on the national quality strategy side as they promulgate what the national quality strategy and the partnership of patients is, and NQF is helping with that, as well as the measure selection process. So I think this is very useful.

CO-CHAIR CORA-BRAMBLE: Okay. Any further discussion before we leave the interaction effects section? So what I'm hearing, just to make sure -- I'm sorry. Luther?

DR. CLARK: I just have a

question. I guess this is for Joel. Could you have the opposite effect? I mean, here there was an attribution to the group males and females. There was only females, but could you have the opposite effect of missing a disparity through this same type of analysis?

DR. WEISSMAN: I'm not sure what you mean.

DR. CLARK: Well, in the Schulman study would it have been possible to have the opposite effect, that he may have found no difference when, in fact, there was a difference?

DR. WEISSMAN: Oh, let's see. Sean probably has a comment on this, but, you know, when you -- it may be that I suppose you could have a significant interaction effect and not a significant main effect.

What would that mean? Would that mean that there's still a disparity? I'm not sure. That's when I tend to look at the four

groups and compare one against the other, so would you go about it in a different way?

DR. O'BRIEN: I don't know. I mean, I think it's possible that if you look at an overall large group, you don't see any differences, but within subgroups, then you see stark differences, and so you could miss something that you wouldn't see if you didn't sub-stratify.

DR. WEISSMAN: I think he was asking the opposite.

DR. CLARK: Yes. No, that's what I asked. I think, you know, our concern would be in not missing a disparity, although you don't want to overstate the disparity, either.

DR. WEISSMAN: Oh, I see what you're saying. Yes, so in some cases, if you don't do the interaction effect, you could miss an important effect within a group. That's absolutely right, yes.

CO-CHAIR CORA-BRAMBLE: I think that was sort of the reason why you wanted to

make sure that it was considered, no?

DR. WEISSMAN: Yes. Yes. Well, yes, I mean, it's funny. The example I gave was that there was also this main effect of blacks and women, right, but it was not telling the full story. It wasn't carefully analyzed when, in fact, there was an interaction effect, but that's true.

You could find not much difference, but there might be differences within one of the groups, so that's a good point. It's another reason to do interaction, but, you know, you can go -- they get pretty complicated pretty fast.

CO-CHAIR CORA-BRAMBLE: Sure.

DR. WEISSMAN: So you want to take a lot of care.

CO-CHAIR CORA-BRAMBLE: Okay. So, not hearing any further comments, I would then assume that it's consensus in terms of Joel's assessment and recommendation for that specific section as it relates to interaction

effects.

All right. You all are on a roll this morning, yes. Sample size consideration. Joel, can you give us a few sentences about that?

DR. WEISSMAN: Yes, just that as we look at the different racial and ethnic groups, especially when we approach a certain amount of granularity, the sample sizes get pretty small pretty fast.

Especially if you're considering, you know, if you're looking at condition-specific rates, it's one thing to have 30,000 members of a health plan, but when you talk about those with AMI, you know, you have a very small number very quickly, so you can imagine that you can get very small.

So there are a number of options that we suggested with pros and cons of each of dealing with small sample size, you know, including rolling up, including using composite measures, and there were a couple

others. You know, looking, grouping over several years is pretty common. You know, a year is a pretty artificial number and that kind of thing.

CO-CHAIR CORA-BRAMBLE: Okay. Thank you. All right, so we'll open up the floor for discussion on this specific topic in terms of sample size consideration, whether there are any additional pros and cons that were not listed, comments in general. Yes?

MS. WU: I would just like to go back to a comment you made before, Joel, about even when you don't have a large sample size, it still might be able to tell you something. It's argument I always get when we advocate for the stratification by, you know, analysis by race.

It's like, "There's not enough." It's like, "Yes, but it might tell you something or have you look deeper into something, might trigger something for you."

So if there's a way to add that

into the report and why that might be important, anyway, I mean, it's not -- you wouldn't report it out, and you wouldn't make journalizations from it, but it's still information that might be helpful.

DR. WEISSMAN: I think we mention that in the report, and we talk about use for internal QI activities. You know, there are some clinicians in the room that could address this better, but, you know, if you talk to them and you want to report out results based on very small numbers, they get very, you know, a little antsy about that.

But when you say, "But, you know, maybe you ought to look, see what's going on internally," they tend to be comfortable with that as long as it's kept internal. That's my impression, speaking as a non-clinician.

CO-CHAIR CORA-BRAMBLE: Okay, Donna?

DR. WASHINGTON: With respect to the options for addressing the small sample

size, the options are listed on page 37. One of them included using a summary statistic.

In keeping with the prior agreement that paired comparisons are preferable to summary statistics, then I would modify the recommendation to say accept all options except for the summary statistic. So that wouldn't prevent someone from using a summary statistic, but it wouldn't be listed as one of the recommendations.

CO-CHAIR CORA-BRAMBLE: Thanks, Donna. Marcella?

DR. NUNEZ-SMITH: Also, as far as the options for dealing with the small sample size, I think one of them was using composite measures, and just to make the notation that in cases where we're looking at measures that are cross-cutting, those would probably not be amenable to composites, which tend to be condition-specific, so that in those cases we may have to look at the other options such as looking at data over two or more years.

CO-CHAIR CORA-BRAMBLE: Okay. Thank you. Sean?

DR. O'BRIEN: With regard to the summary statistics, I think there's another issue. The summary statistics are the type that we were talking about yesterday where you're rolling up paired comparisons into a single number.

If each of those paired comparisons that are used to form the summary statistic are highly variable and noisy because of small sample sizes, your overall summary may still have a sample size issue that doesn't go away, so I think be careful about that one. I may have had a second point, but I --

CO-CHAIR CORA-BRAMBLE: Okay, thanks. William and then Marshall?

DR. CHIN: I will say the Committee started a powwow on composite measures, but I want to give Joel the chance to defend it in terms of your massive

experience, because you were basically in government trying to do this. What's the best case for summary statistics?

In other words, I get this impression that when it came down to practicality, it was like the only option a number of times, but if you could talk a little bit more about what you thought were the pros, or are you agreeing in terms now with these measures you're comparing against composite measures?

DR. WEISSMAN: Yes, I spent a couple years as a Health Policy Advisor to Secretary Bigby in Massachusetts, and while I was there we spent a lot of time on disparities issues. One of the things we dealt with was a state report card on disparities, and it was in development when I left after my two years there.

We were considering a number of summary -- we tried to break it down by the major OMB categories, and that's, I think,

where we left it, but in some cases we were considering other kinds of summary indexes. Where it really came into play was in the pay-for-performance program that, actually, Medicaid developed while I was there.

There, they just didn't have the numbers, and so they, as a practical approach, they used -- they used composites. You know, they had a composite over all the conditions, and they used a summary statistic, and they came up with one number per hospital.

In that case, you know, I thought it didn't really work that well, and we actually ended up writing an article saying that that doesn't work that well, but just, you know, when you come back to --

You know, we can make all these recommendations about how granular to get, how to stratify, and all that kind of stuff, but when you start churning out these numbers, you get a lot of numbers very quickly.

I don't think there's a right

answer, unfortunately, but in some cases a summary statistic may really efficiently summarize what's going on, that there is a disparity, and I guess the recommendation we're making is don't use it blindly, that it can be -- that it can be a useful tool, that it can really -- to use Sean's term, you know, a data reducer, right.

It can really reduce a lot of stuff, but, you know, but use it carefully and understand that's going on. If there's stuff that makes you uncomfortable such as directionality issue or there are value judgments that are being made in terms of how those things are created, then those ought to be made explicit and transparent, just like, I think, any of the composite type of statistics that are used in public reporting.

CO-CHAIR CORA-BRAMBLE: Thank you. William and then Norman.

DR. MCCADE: That was what my confusion was, because it seems like the first

three of the four options are all summary statistics, tools, at least, and I wasn't really quite sure as to Donna's comment that if we were going to choose one and exclude summary statistics that we would be also using summary statistics in any of it.

The only one that doesn't seem to be that way is the combined data from two or more years where you're actually using the true data set, and although it's slow to accumulate, it seems like it's probably the truest measure.

CO-CHAIR CORA-BRAMBLE: Norman?

DR. OTSUKA: I don't want to sound like too much of a contrarian, but I'm not a statistician. I'm a clinician in the grassroots, and this is a national forum. If you present me with some data with small sample size, I wouldn't really look too closely at it, so I'd be careful about getting too granular in reporting small sample sizes like you suggest. As a clinician, busy

clinician seeing X number of patients, I wouldn't give that a second thought.

CO-CHAIR CORA-BRAMBLE: Okay. Noted. Any other comments? Sean, did you have a comment?

DR. O'BRIEN: Yes, I mean, I think I more or less agree with these recommendations, but at some point we need a recommendation that is more specific to what this group is doing. When there is a Call for Measures, measure proposals will come in, and they need to be evaluated for basically their -- on different criteria, including validity and reliability.

There needs to be some type of framework for assessing when is sample size adequate or not adequate. I'm not sure we'll come up with anything that's really strict and operational, but that will be the issue is when do we say the sample size is too small.

I think another -- for NQF guidelines there are specific measure

developers that are supposed to provide evidence regarding the reliability and validity of the measures you're submitting, and reliability does include some type of assessment, I think, some type of assessment of whether the data are precise enough to be useful for some purpose.

I mean, I think -- so I don't know exactly any threshold or how to -- at some point, that's what I think we'll be grappling with when measures come in.

CO-CHAIR CORA-BRAMBLE: Okay. Any other comments from the group regarding sample size considerations?

CO-CHAIR ANDRULIS: Just, Joel, in your section on --

CO-CHAIR CORA-BRAMBLE: I don't think I acknowledged you.

(Laughter.)

CO-CHAIR ANDRULIS: I'm sorry. Oh, okay.

CO-CHAIR CORA-BRAMBLE: Go ahead.

CO-CHAIR ANDRULIS: Just a minor note, because you did include in this section. You talk about Weinick's work and the reference to even anecdotal evidence maybe useful, and I'm thinking of the -- it may be in the inclusion and guidance whether there is a need also to acknowledge that there are these kind of exceptional or circumstantial issues that should also be added or considered to accent these points with regard to sample size.

In other words, you may lose, but there may be some really singular events that point out something about what happens. So that so-called anecdotal evidence that you raise in reference to Weinick's work, I just wanted to get your thought about where you saw that fitting in the mix, since it is in that section.

DR. WEISSMAN: Well, I think it was the point I was making earlier about internal QI activities. What was the -- I

mean, I think, you know, I hesitate to use the word, but the sentinel case, right, the exceptional case. What was the famous book, Falling Down, the Hmong family? You remember that?

CO-CHAIR CORA-BRAMBLE: The Spirit Catches You, and You Fall Down.

DR. WEISSMAN: Thank you. The Spirit Catches You, and You Fall Down, right. I mean, you know, isn't that what got us all started on this? I mean, it was a single case, you know, well written up and well researched, and, by the way, if anybody hasn't read it, they should.

You know, I think that changed a lot of places, so I think the point about making that, you know, there are times when statistical stability doesn't tell the whole story, where, you know, we have to throw the statistics out the window and kind of look at, take a very patient-centered approach and learn something from it.

So I think that as a recommendation, you know, following on what Helen said, you know, this is more about just measure reporting and public reporting but also trying to change practice, and one way to do that is even if you don't have enough cases, these are -- these may be -- some exceptional cases may be worth investigating.

CO-CHAIR CORA-BRAMBLE: Yes, Romana?

DR. HASNAIN-WYNIA: I just want to follow up on that and really kind of support Joel's comment. So, you know, I use this example from a few years ago in terms of some work that we were doing looking at the Hospital Quality Alliance measures, particularly the measure to door-to-balloon time PCIs.

So we started to look internally at Northwestern at our numbers, and, you know, we ran into small sample size issues, especially when we started to look at

different racial and ethnic groups, but we started to see some patterns where Hispanic women, it was taking them longer in terms of meeting that measure -- let me just use that term -- as well as African-Americans.

We continued to kind of ask whether that story was holding in other regions, in hospitals on the West Coast and in Florida and Texas and so forth, and we saw that pattern repeating. That was really informative, and for many of the hospitals the sample size was quite small, but it revealed a story, and it revealed a story that actually led to further research to look at it more empirically.

So those anecdotes are really important, and I do think, you know, the comment that Norman made in terms of if you see really small numbers, you start -- you know, a small sample size, you may question the validity of that information, but in terms of internal information and internal quality

improvement and trying to understand the story internally, I think those numbers are important no matter how small they are. So I don't want to lose sight of that in terms of what we put forward in this Committee.

CO-CHAIR CORA-BRAMBLE: Good observation. Thank you. Any further comments before we leave this section? Yes?

DR. MOY: Listening to the conversation, I think it's important to know when it's a sample and when it's not. So we don't mind for QI purposes, because they're really not samples.

We have the hospital population or the health plan population, and in truth that's how these measures will often be used. They're populations. They're not subject to sampling error.

CO-CHAIR CORA-BRAMBLE: Okay. If there are no other comments, then we'll move on to the next section, and we've already done -- we've spent, actually, a fair amount of

time talking about other socioeconomic variables and considerations. We sort of backed into that discussion, but I'd like, Joel, if you can tee that up, and then we'll have a discussion about that.

DR. WEISSMAN: Yes, I think it's important to differentiate this risk -- this adjustment activity from the earlier risk adjustment activity. So before we were talking about risk adjusting an outcome or a measure for race and ethnicity, and you have to consider the use.

So the idea there would be that if you were going to use it for high-stakes reporting, for public incentives, you know, the question was should you risk adjust for the underlying racial and ethnic population, and the position of NQF and this Committee, I think, was that stratification is a better way to go.

This is about one step down, and now you are focused on characterizing the

disparities in a population, and so you're looking to make it simple, black-white differences. The question is if you find black-white differences, should you further adjust for socioeconomic status, say, for payer or income?

What often happens is if you do that, the disparities go away. Sometimes they remain, and I think that's what, you know, the IOM report was about, that you can do that in a lot of cases, but a lot of times, especially in small sample sizes, you know, these significant differences go away.

The question we ask is if they go away when you adjust for socioeconomic status, does that mean that the disparity doesn't exist? We were uncomfortable with saying yes to that question, answering yes to that question, so we recommended that racial and ethnic and language disparities not be adjusted for socioeconomic status.

CO-CHAIR CORA-BRAMBLE: All right.

Comments? Thank you, Joel. Go ahead.

MS. WU: This is more what I understand it as control for socioeconomic status, Joel. Is that -- yes. Okay.

CO-CHAIR CORA-BRAMBLE: That's a question, Joel, for you.

MS. WU: I got the answer. Anyway --

DR. WEISSMAN: Yes.

MS. WU: So, I actually agree with that, and it also addresses the concern I think some of us have in working in the field where a lot more folks are focused on the socioeconomic status as a disparities indicator and trying to address, and that's an important issue, income disparities, and not -- and using that as a proxy for race-ethnicity and language, which, you know, is a concern, so I definitely would agree with the recommendation with the report.

CO-CHAIR CORA-BRAMBLE: Thank you. I do have one question. There is some

literature that looks at wealth, as opposed to income, as a better indicator, and I just wanted comments from you, Joel, and then some of the other folks in the group whether that's something we need to look at.

DR. WEISSMAN: Yes, I think there are some experts in the room that are better than me at using various measures of socioeconomic status, but wealth is certainly one of them. They each have pluses and minuses in terms of ability to get the information, stability over time, you know, generational effects, and so on.

Wealth is certainly better, for example, for the elderly, right? I mean, they don't work, so their incomes are low, and some of them may have very high wealth, so there are different ways to go about it.

CO-CHAIR CORA-BRAMBLE: Okay. Marcella?

DR. NUNEZ-SMITH: So just one quick follow-up point to that, which is true.

I mean, David Williams and others have written extensively about using wealth rather than income or other measures.

Some of what we're going to end up discussing is going to be related to what's limited in the databases people will be looking at nationally where to date we don't have wealth and other measures like that, so that's going to be one of the issues there.

I think, just to clarify the recommendations, so I also agree we should not be further adjusting and controlling for those other variables, but is there a second part of the recommendation that says we should be doing separate stratification by some of these other indicators such as payer or anything, any other --

DR. WEISSMAN: I thought it was -- you know, it's worth -- it's worth, you know, further stratifying it and looking at the differences. There's a difference between, I guess, some of the contributory factors and

sort of mitigating the thing, which explains it away, right.

So income, wealth, insurance status, those are all contributory factors, and if you find differences, say, between Latinos and whites, chances are it's going to be because of wealth, income, and insurance status. It's worth looking at that.

If you're trying to improve quality of care, it's worth acknowledging that those factors contribute to the differences, but to say, "Well, you know, Latinos are more likely to be uninsured and have lower incomes, and that explains everything, and therefore there are no racial-ethnic disparities in my health plan," I don't think is where we want to go. So I'm not sure I'm articulating it as well as I can, and maybe somebody can work on that better, but that was where we were coming from.

DR. NUNEZ-SMITH: Right, so is it -- so then is it, in terms of operationalizing

it, it's sort of you have multiple independent analyses. Is that the understanding? So you have one analysis, race-ethnicity only. That's your stratification.

Then you take the data set, do another stratification by payer, let's say, but that's what you're looking at in that analysis is just payer. You're not looking at race-ethnicity and payer. I mean, I'm just trying to understand if that's the --

DR. WEISSMAN: Well, no, you could do both. I think we -- I think we had some cool graphs from RWJ that did a very nice job. I don't know where they are now. Anybody know where they are, what page?

CO-CHAIR CORA-BRAMBLE: What page are you on, Joel?

DR. WEISSMAN: That's what I'm looking for. There were some nice graphs from RWJ that showed --

MS. WU: But, Joel, isn't it --

DR. WEISSMAN: It broke down --

CO-CHAIR CORA-BRAMBLE: So pages 43 and 44?

DR. WEISSMAN: Oh, maybe.

MR. WU: But, Joel, isn't it different? Isn't it different statistically when you stratify by certain indicators versus control for? I'm not a statistician.

DR. WEISSMAN: You know, it is different, but it has the same purpose, because you're showing how different -- and I'm not a statistician, either.

DR. NUNEZ-SMITH: Right, I mean, yes, I mean, I think the point where I -

DR. WEISSMAN: So it's always dangerous.

DR. NUNEZ-SMITH: Right. I mean, I'm not actually saying something different. What I'm saying is instead of you looking at race and income together in an analysis you're looking at them separately. I mean, that's the way that it's presented in the --

DR. WEISSMAN: Well, except on

page 43 and 44 you can see that you can also look at them together, right, so not just separately, but you can, in fact, look at them together.

I think maybe where this Committee needs to sort of focus on is I was simply illustrating different ways of approaching this, but in terms of your recommendations to how to use the measures, it may be, you know, just because you can do it doesn't mean you should.

CO-CHAIR CORA-BRAMBLE: Okay, so I want to -- there are a few people that I want to acknowledge. I know you had a comment. Elizabeth, do you have one? Okay, so let me do this. Let me start. Let me start with you, Elizabeth, then you, Dennis, and then you, Edward. Yes?

DR. JACOBS: The one thing I was going to say about wealth is I'm not sure how practically you'd measure that in this context. I mean, people don't even want to

answer questions about their race-ethnicity, and I don't think a lot of healthcare organizations collect that information. I mean, while it might be good to think about it, I think it really raises questions in people's minds, as Romana has shown, about why you're asking that information.

CO-CHAIR CORA-BRAMBLE: Thank you. Dennis?

CO-CHAIR ANDRULIS: Before we decide not to risk adjust for SES, just I guess I'm a little haunted by some of the more powerful studies that have come out to show that even when you control for SES that there are still disparities related to race and ethnicity.

You know, I think some of the work we did in Prince George's County where we looked at the SES within Prince George's and we were reminded over and over again about how it's one of the wealthier African-American, primarily African-American counties. We said,

you know, we're still finding disparities within that county.

I talked to some folks about this, and they said there are all sorts of conjectures as to why this was happening. While I generally agree with the discussion around the SES, I'm concerned about those aspects, those findings being lost or being not potentially considered should we just blanketly say SES shouldn't be controlled.

CO-CHAIR CORA-BRAMBLE: Okay, so Edward, and then there's a comment on the phone, and then you, Grace. Yes?

DR. HAVRANEK: I think this is the first time that I disagree with your recommendations. So if you show a black-white difference and then you adjust for socioeconomic position and you show that those differences --

Let's say first you show that they don't go away, which is, I think, what Dennis just alluded to. That to me implicates

mechanisms such as bias and prejudice as being really important and leads us in an important direction in terms of trying to address the disparity. To me, that's a really useful finding.

The opposite case, that you adjust for socioeconomic position and the bias goes away, to me suggests that the primary driver of the disparity is socioeconomic position, so that's what we should be focusing on, and that's the source of the disparity.

I think we are discounting the possibility that there is, you know, bias and prejudice and stereotyping based on socioeconomic position that is itself producing a disparity. So it may be that, you know, poor whites are being -- are subject to a disparity here in this by the same mechanism by which poor African-Americans or poor Latinos are.

So I think that, you know, it's all in how you interpret it, but to me I think

the potential to interpret the results of the adjustment in a meaningful way that moves us forward really can't be discounted.

DR. WEISSMAN: Can I?

CO-CHAIR CORA-BRAMBLE: Joel?

DR. WEISSMAN: Yes, I'd like to respond in a couple of ways. One is -- one is to kind of push back directly. Let's say, you know, let's say you didn't stop at adjusting for socioeconomic status. You adjusted for quality, the housing stock. You adjusted for availability of bus lines, you know, whether they have time to get off from work.

You can have all these contributory factors, and the more you adjust, these are things that could make the disparities go away. And I would say that as you go deeper and deeper, you know, it becomes less and less justified.

Then, the other answer I would give is that let's say you're black or Latino, and you're trying -- and you're looking at a

health plan, and you're trying to -- among other things, based on NQF measures, that health plan is reporting on its equitable care. You want to know whether or not they treat blacks and Latinos equitably to others.

If you adjust for socioeconomic status and the differences go away, and, Dennis, I understand that there are some -- you're thinking like a researcher, but, you know, the differences go away. Then you're going to say, "Oh, okay." I don't think that's going to fly, so that's --

DR. HAVRANEK: Okay, I mean, I can see that. I mean, I think you're right. Thinking as a researcher is very different than thinking as public reporting, so in regards --

DR. WEISSMAN: Yes, it's hard to take off the researcher hat, yes.

DR. HAVRANEK: No, I think that's right, but, yes, I concede.

CO-CHAIR CORA-BRAMBLE: Okay,

thank you. There's a comment on the phone. Please identify yourself before speaking. A comment on the phone? Evelyn? Okay, we'll go on to Grace, and then we'll come back to Evelyn.

MS. TING: Thank you. So, I am actually in agreement from kind of the very practical application insights you're offering in that, you know, I do agree that when you do adjust for socioeconomic status, sometimes that goes away.

I do support Edward's comment that that may lead to a very different type of intervention from a standpoint in that by not looking at it. So we actually do look at both in looking at our data, but I think that, you know, where there are trends to be investigated, then we would delve further.

But I think it's also very important to know that I personally observe in our own data among commercially insured -- you know, specifically it was a population

specific to Wellpoint employees, so all employees could all speak English, because you have to work at Wellpoint, have insurance coverage, because it was our house account, and still we uncovered health disparities.

So, you know, I wouldn't totally say that socioeconomic is everything and the cause of disparity, because, you know, here is a population where we're all fairly comfortable, at least, for the most part, and so we saw the disparities.

So that, I think, argues what Joel is pointing to, non-stratified, but occasionally you do find the patterns where it tends to be more strongly socioeconomic, and that takes a completely different type of intervention than, say, something that's purely racial and ethnic. So I think that there is room for both. I don't want to say let's not stratify them all or adjust for socioeconomic.

DR. WEISSMAN: Yes, I mean, that's

absolutely right when you're trying -- the classic approach to access research, and I've done this with the uninsured and, you know, racial and ethnic disparities is you control for everything you can think of.

If you still have a disparity left over, then that's sort of considered, you know, the "R" word, racism, right, that something else is going on, but, in fact, there may be other things that are going on that you still will want to address so that you can reduce those racial and ethnic disparities.

MS. TING: Right. If the ultimate goal is to really truly reduce health disparities, you need to be practical. Like, I mean, we can talk about these measures and studying the effects, but at the end of the day, if your interventions don't speak to the target population and has no impact, then you're never going to impact or move these measures in a positive manner. So I would say

that let's not discount that.

CO-CHAIR CORA-BRAMBLE: Okay. Ernest?

DR. MOY: I just wish that we actually could make disparities go away with adjustment. Then we'd solve all our problems very easily, but I think the point is that we don't make disparities go away when we adjust.

We simply are identifying the mechanisms by which they are created, but I think from the conversation, because so often people do this adjustment and say, "Oh, there's no disparity. It went away," that that's the main reason why not to do it.

You get the same information by stratification, but then you still see the different groups there and the differences across the groups now stratified by whatever mechanism you're postulating is the affecter. So I think, you know, this conversation to me is an argument not to do the adjustment but rather to show the information as

stratification where you do see the -- still see the different racial contrasts.

CO-CHAIR CORA-BRAMBLE: William?

DR. MCCADE: Well, this harkens back to a previous conversation about small sample size. When you try to stratify, you actually reduce your sample size that's available to you, as well, and so that has an adverse effect on those populations that have very small numbers and makes it even harder to collect the data when you do more stratification that way. I think SES is certainly an important thing, but I think if it adversely affects your ability to collect numbers, then you might want to rule it out.

CO-CHAIR CORA-BRAMBLE: Okay. Thank you. Any other -- do you have a comment, Grace?

MS. TING: I do, and just in terms of, I think, looking at wealth or income, it's possible not to actually physically collect that information but to derive that through

geocoding.

CO-CHAIR CORA-BRAMBLE: Correct.

MS. TING: So I wouldn't completely rule that out if you wanted to look at it that way, but, you know, the primary source collection is not necessarily the way to go if you want that kind of information.

CO-CHAIR CORA-BRAMBLE: Thank you. The individual on the phone?

MS. MCELVEEN: Yes, Operator, if you can hear me on the phone, can you unmute and open the lines if they're --

OPERATOR: All lines are open.

MS. MCELVEEN: Yes, Evelyn, if you are still on the line, yes, you can proceed with your question, and please introduce yourself.

MS. CALVILLO: Hello, I'm Evelyn Calvillo calling about the sampling, the sample size. Nobody has mentioned the sampling plan except stratification, and, you know, I think you need to consider even with

stratification.

So I think it needs to be mentioned somewhere that the sampling plan is very important. I mean, if you do a stratification based on convenience, there are going to be some differences in your outcomes. That was my comment.

CO-CHAIR CORA-BRAMBLE: Okay. Thank you so much, Evelyn. Any further comments about this? Yes?

DR. WEISSMAN: Actually, it's interesting. I thought that the person on the phone was going to say something different, which brings to mind I don't -- when she talked about the sampling plan, I don't know if NQF makes recommendations about how to sample cases, because you don't do the entire population, but if you're going after -- if you're planning on identifying racial and ethnic disparities, would a recommendation be, and this was not in our report, to over-sample minorities?

DR. BURSTIN: At times, depending on the measure, there is a sampling. There is always that aspect of the submission form which asks for sampling information if appropriate, so if there is sampling to be done, it would be part of the measure specs.

DR. WEISSMAN: And would you make the recommendation to over-sample minorities?

DR. BURSTIN: Not necessarily, but that might be something for this group to consider.

CO-CHAIR CORA-BRAMBLE: Ellen?

MS. WU: That actually came --

CO-CHAIR CORA-BRAMBLE: I do acknowledge you, Ellen, sure.

MS. WU: Sorry.

CO-CHAIR CORA-BRAMBLE: Go ahead.

MS. WU: I actually noted that in my report. It's interesting that it only came up now, but I definitely think that that's really, really critical. You know, California has our California Health Interview Survey in

five different languages, and they over-sample.

They over-sample in rural areas, in different populations, and I think that given the small sample size issue but really trying to understand the populations and sub-populations that we really should encourage over-sampling.

CO-CHAIR CORA-BRAMBLE: So, am I hearing, then -- I hear that there are individuals that are recommending that. Is that sort of the consensus in terms of the group that we should specifically recommend over-sampling of specific populations?

MS. YOUDELMAN: I certainly was going to support, and I think since we're focusing on race-ethnicity language I would certainly make the recommendation that those three be over-sampled, and then there might be some suggestions about even over-sampling some of the subgroups.

If you're talking about, you know,

Asian-Pacific Americans, Pacific Islanders, do you over-sample some of the subgroups, as well, depending on maybe geography or other factors that come into play where you might be able to get broader sample sizes?

CO-CHAIR CORA-BRAMBLE: Okay. Colette?

DR. EDWARDS: This conversation to me is reminiscent of what we were talking about yesterday in terms of absolute and relative and trending, so is this another situation where the answer might be to do -- to look at both ways and at the trend and then come to some conclusion after that?

CO-CHAIR CORA-BRAMBLE: Comments from the group? You know, my counter argument to that has to do with the feasibility of doing all of this when you get to the practical level.

DR. EDWARDS: I think that once you put that filter, a lot of this is going to melt away, but if you have that as a starting

point, if you can do it or do it to some extent, is there still value?

CO-CHAIR CORA-BRAMBLE: Sure.

DR. EDWARDS: A lot of this is just going to be totally not doable any time soon or something that is derived from some other measure as a proxy.

CO-CHAIR CORA-BRAMBLE: Any other comments -- excuse me -- from the group? Okay, I then am going to pass on the baton to you, Nicole.

MS. MCELVEEN: So, we are going to move on to Section 5. Section 5 is on page 47 of the comprehensive report.

Specifically within this section we're going to be looking at 5a, 5b, and 5e, so that's what should be achieved from disparities measurement, what should be avoided, and some challenges in program design, as well as the policy implications.

Mass General had a nice slide where they kind of summarized this, and, Joel,

I'm going to just ask that you provide that recap, and we have some additional questions for the Committee to consider around those sections. I have teed up that slide for you.

DR. WEISSMAN: Oh, good. Well, the first thing in terms of what to achieve we shamelessly stole from a previous NQF report by Eric Schneider and just thought that it applied directly to what we were trying to achieve here with disparities reductions.

You know, so these are kind of what do you want to achieve with this, with the outcome of this group, and it's to monitor progress, inform consumers and purchasers, and I think, you know, you really think about the minority patient choosing among different health plans, different hospitals, different health insurance exchanges in the future.

They're all going to rely on this kind of information, and I think that's an important thing to keep in our heads to stimulate competition among providers, the

idea being that you shouldn't be able to be successful via risk selection.

You ought to be successful by competing on providing the highest quality of care to minority populations, stimulate innovation, and really promote the values of the health system. I thought Eric in that earlier report did a great job of explaining those things.

Then what to avoid, you know, we sort of went through the literature and brainstormed a bit on all of the unintended consequences mostly of high-stakes kind of reporting like this, either public reporting or pay-for-performance or other kinds of incentive programs.

There's the idea of cherry-picking or the opposite of that, which is my new favorite term, lemon-dropping, which everybody is familiar with. The rich get richer. People understand that early analyses of the pay-for-performance programs have shown that

the better resourced providers do better and then get those incentives and then do even better still.

Teaching to the test means that you kind of just focus on the specific measure and nothing else. Sometimes you over-focus on that, and I think Joe gave the example of if the idea is to give pneumonia patients antibiotics in an appropriate time frame, well, anybody that comes in with a cough, you give them antibiotics first and ask questions later, and that's a scary thing.

Gaming the system, you know, everybody talks about gaming the system. Since I'm not a provider and I don't see a lot of examples of it, it's hard to come up with some examples. I mentioned one in the report about an interesting phenomenon out in Kaiser in -- was it Washington or Oregon?

Dave Campbell was telling about it, and he actually presented it at a session that I ran at Kennedy Health where he said

that, you know, the young Asian female physicians were leaving the practice, which was heavy in minorities, and going to a more white community, because their scores got better, and they were eligible for more incentives. It was -- you know, he was really trying to work on that sort of thing.

You want to avoid a situation that encourages that sort of gaming, the ability of minorities to benefit from color-blind QI activities. So you may have, you know, a quality improvement activity that you think benefits everybody, but for some reason or another minorities -- and this kind of comes into play.

Is it -- you know, are the underlying socioeconomic issues or cultural issues that might explain some of these differences, do they make -- do they reduce the ability of minorities to benefit from that program?

Then this last one is actually

sort of a bigger topic. I don't know how it comes into play with the NQF's recommendations around this, but, you know, Romana and I have done a lot of work on this area, and it's the between-and-within phenomenon.

Basically, that says that if you look at a wide, say, geographic-wide numbers on disparities, you've got two things going on. One is the within phenomenon, meaning within a provider or an organization minorities may be treated differentially. That's the who you are.

But as other researchers have shown and we've shown, a big part of that is also where you go, and it may be -- it's often that minorities tend to go to high minority providers that are under-resourced and have lower quality of care for everybody and that the extreme cases that everybody is treated equitably. It's just that minorities go to lousy places.

You know, it turns out to be a mix

of that, and there are different policy responses to each of those phenomena, right? I mean, if it's within, then that's kind of a cultural competency issue, and that's a pay-for-performance issue, because you're dealing with the providers within an organization, but if the -- if it's really a between phenomenon, meaning that minorities tend to go to overall lower minority providers, then that's a resource issue.

You know, that gets back to my idea of maybe paying those high minority hospitals more money up front, because they have a more challenging population and so on. So there are some -- that's a bigger topic, but that's what you want to avoid.

MS. MCELVEEN: Thank you, Joel. So the question that we are proposing to the group is if there are any additional issues or even solutions that should be included and the Committee's views of the options that have been presented thus far.

CO-CHAIR CORA-BRAMBLE: Okay, so we'll start with Dennis, and then we'll just go around the table.

CO-CHAIR ANDRULIS: I don't quite know how to phrase this, but one other issue that is at least around the edges of this is, for lack of a better phrase, kind of almost a geographic -- it's a combination of geographic preference and redlining that's going on among providers where there is kind of a self-fulfilled prophecy that comes about.

So, for example, especially in some of the inner-city hospitals, I know Denver has had this example where hospitals have been moved out of the city into more affluent suburbs. Also, the poor -- we've done tons of research on this. We have poor suburbs. People aren't so interested in providing care in that area.

By that measure, by that indicator, it creates an inherent, at least a challenge if not a potential major impact on

quality, because either services aren't there or the services are not well linked, coordinated. Quality of care becomes an issue.

So, to me, one of the points of -- I don't know whether I'd call it avoidance, but to me there is a geographic characteristic set that's emerging among a lot of provider systems that is likely to compromise quality of care for poor and a lot of minority populations as providers say, "You know, I'm not so interested in that area. I'm interested in more affluent areas."

CO-CHAIR CORA-BRAMBLE: Okay. Thank you. Ernest and then Francis.

DR. MOY: This relates to what we want to achieve from disparities measurement, and I think that one thing not on the list is, I think, in theory, this measuring disparities should make quality improvement more efficient.

So if you're a health plan or a

geographic area and you have a quality problem, you could apply resources everywhere to try to improve performance everywhere, but if it happens to load on a particular population, you can then target that population and, in theory, improve quality more efficiently. So I think that shouldn't be lost as one thing that we hope to achieve with disparities measurement.

CO-CHAIR CORA-BRAMBLE: Okay. Thank you. Francis?

DR. LU: Yes, perhaps this will be covered, I think, in the sections following, but in terms of the 5a, and I don't know how comprehensive you're meaning these bullets to be for this report or for the eventual rollout aspects here, but I think another obvious bullet point would be, in addition to informing consumers and purchasers, I think it's also to inform accreditation agencies or government regulators or other oversight bodies that are concerned about disparities

that they are also informed about how providers are performing in this area.

CO-CHAIR CORA-BRAMBLE: Okay. Thank you. Marshall?

DR. CHIN: Joel, this was a very strong part of the report. Just a sort of subtle point. When you're talking about sort of the between versus within difference, you mentioned that there are different policy implications depending upon where the lesion is.

You said if it was within, then it's sort of a provider competency issue. It could also be, perhaps, even more powerfully, assuming it's an institutional racism issue, so it has to be very careful in terms of perhaps raising that as another possibility, as opposed to being a cultural competency issue. It's probably not as important as the institutional organizational barriers put in place.

DR. WEISSMAN: And when you're

using the term cultural competency, you're implying that it's the individual provider, the individual practitioner, and I guess, you know, you could also apply cultural competency to the institution as a whole.

DR. CHIN: Right. It probably goes beyond cultural competency in terms of potentially basically economic barriers or other ways subtly put into the system that is not so much provider-directed but it's an organizational policy that leads to differential outcome.

CO-CHAIR CORA-BRAMBLE: Okay. I'm sorry, I can't see your card right next to you.

MS. CUELLAR: Lourdes.

CO-CHAIR CORA-BRAMBLE: Lourdes.

MS. CUELLAR: My focus is on the motivating providers to improve performance. One of the things that really hasn't been brought up is, for lack of a better term, a middle person where you have either physician

practices, hospitals, clinics that partner with -- an example, church groups have been effective. Promotoras de Salud have been effective, but measuring when you have sometimes the voices of few sometimes can really raise awareness from the consumer standpoint.

Those have begun to be measured, but there's not a whole lot out there, but in certain communities church groups I know for sure and the Promotoras de Salud in Texas are very effective, particularly with prenatal care, immunizations, so that's just something to consider as a potential measurement.

CO-CHAIR CORA-BRAMBLE: Thank you. Elizabeth?

DR. JACOBS: Yes, I just want to follow up on what Marshall said in thinking about unintended consequences, because I worked for 12 years at this institution, which is one of these organizations that didn't, I'm sure, on all sorts of quality measures we

didn't meet them, weren't even close, but that doesn't mean that the institution wasn't trying really hard. It was just working under limited resources.

I think one of the unintended consequences of this is sort of -- I mean, I sort of bristle sometimes when I read these papers where someone, you know, does these big analyses and say, "Look it. Eighty percent of African-Americans go to these poor performing hospitals."

And it's like it's not because -- it's because those hospitals actually don't have the right resources to actually provide the care, and so if there is some way that these measures can also indicate -- I mean, I don't know if there is some way to actually reflect --

This may be very pie in sky but some way to reflect what are some of the issues that contribute to some of these disparities. Are there -- it's not --

I don't think it's necessarily institutions aren't trying hard. It's just that they can't -- or the doctors aren't good enough. It's just, you know, if your patients can't get a colonoscopy, then can't get a colonoscopy because there's no appointments. I mean, that happened at my institution.

So I think this is one of these unintended consequences, things that I'm not sure I have a lot of ideas for how to resolve right now, and maybe I'll come up with some on the plane ride home, but it's just something I'd like us to be aware of.

I don't want to necessarily penalize organizations working for these people, for people who are traditionally disadvantaged, because I think a lot of them are just trying. They just can't do it under the current environment.

CO-CHAIR CORA-BRAMBLE: Okay. So Colette and Mary, and then I have a comment. Colette?

DR. EDWARDS: With regard to the goals, do we want to explicitly call out cultural competency and health literacy and then, kind of to Liz's point, allocation of resources?

CO-CHAIR CORA-BRAMBLE: I mean, I've heard the allocation of resources issue raised time and time again, and I could not agree with it more, you know, wholeheartedly, so I definitely think we should include it.

DR. EDWARDS: Because we don't -- we aren't officially calling any of those things out, and I think it may be worthwhile.

CO-CHAIR CORA-BRAMBLE: Understood. Mary?

DR. MARYLAND: Along the same thought process in terms of thinking about allocation of resources, and, I believe, to capture Lourdes's point that some version of what in the cancer world is called a navigator, so how do you connect what it is you need to the person who needs it and do it

efficiently, so if there's a way to maybe identify that type of a resource, because I think that can help take care of the gap process.

CO-CHAIR CORA-BRAMBLE: And akin to the Promotora de Salud that was mentioned, it's similar, the patient navigator. Two things that at least in the pediatric world it's worth mentioning.

That has to do with the children with special healthcare needs and how that works is sort of a confounder, because these kids require an incredible amount of time and resources. And if you measure the outcomes, it's still maybe low, but it has to do with what you're dealing with in terms of patient population.

The other one has to do with access to subspecialty services. Many of our patients are Medicaid-enrolled patients, cannot get the services they need, because the community providers basically said, "We do not

accept Medicaid patients," so I think somehow that needs to be included in the report.

I'm sorry. Elizabeth? I'm sorry, you said it was Liz.

DR. JACOBS: I just have --

CO-CHAIR CORA-BRAMBLE: Liz or Betsy, which one?

DR. JACOBS: Liz.

CO-CHAIR CORA-BRAMBLE: Liz. There you go.

DR. JACOBS: I have one follow-up to what you were saying, Mary, and Lourdes, too. Are there NQF measures of use of patient navigation systems, because that might be something? That might be a -- sorry to use the word -- sentinel measure, so that just came to mind as we were having this discussion.

CO-CHAIR CORA-BRAMBLE: Mara?

MS. YOUDELMAN: And I'll add to that use of language services, and I think that's --

CO-CHAIR CORA-BRAMBLE: Use of what?

MS. YOUDELMAN: Language services.

CO-CHAIR CORA-BRAMBLE: Right.

MS. YOUDELMAN: And that may be another piece that we want to bring in with sort of the cultural competency, as well, as one of the things that -- well, not this slide, the other slide -- but to encourage the planning for and provision of language services so that if you are identifying that there are disparities based on language.

That also goes back -- I think, Mary, you were talking yesterday or Colette about, you know, we need to make the rationale for why we're doing this. Then Romana said sometimes it's easier on language services, because if you collect that data and you analyze that data, there's a direct intervention of you need to get the language services in place, and it helps with planning, so if we can also make that point in this

process, it might be useful.

CO-CHAIR CORA-BRAMBLE: Thank you. Luther?

DR. CLARK: I've been listening to this issue of the resources, which is a -- which is a real problem, and I was wondering in the goals could one of them be looking at the impact of reducing disparities on reducing healthcare costs, because if there is some indicator that this is really saving money, perhaps there would be some increased incentive to invest, you know, in these facilities or in these efforts to reduce the disparities further.

CO-CHAIR CORA-BRAMBLE: I think that's a great point. If I try to apply it in terms of practical terms and looking at, for instance, the obesity problem in the District, we haven't really been able to convince the payers that they need to increase payment or have a different payment methodology because of the cost associated with obesity.

So, I mean, I hear you. I agree with you. You know, I just wonder how successful it is as a strategy, but I agree with you.

DR. CLARK: But maybe that's the opportunity for innovation, because if we could do that -- I mean, it's not easy to do, and --

CO-CHAIR CORA-BRAMBLE: Agreed. Agreed.

DR. CLARK: -- I may not know how to do it, but I think teeing it up in some way is important, particularly in this current environment.

CO-CHAIR CORA-BRAMBLE: Agreed.

DR. CLARK: That may help.

CO-CHAIR CORA-BRAMBLE: Okay, so we're going to --

MS. YOUDELMAN: Can I just pick up specifically on that, because there was some research done by the Joint Center that specifically is looking at the cost of

healthcare disparities. It was done through health reform, so that might be a report that folks can refer to, and we can get that link around to folks. Dennis, you worked on that?

CO-CHAIR ANDRULIS: Yes, that's Tom LaVeist's work.

CO-CHAIR CORA-BRAMBLE: Okay. All right, so Norman, and then we'll start around this side of the table. Yes?

DR. OTSUKA: I think Francis mentioned something about going beyond these goals, but of interest to me is education, particularly of residents, and culturally competent care is part of the ACGME, one of the six core competencies, but it's sort of in the fine print in the last line. So in reporting I think consumers -- I think it mentions something about consumers and buyers, but I guess education, residents, physicians or consumers, as well.

CO-CHAIR CORA-BRAMBLE: Thank you. Len and then Francis.

MR. EPSTEIN: Yes, at HRSA we really focus on integrating culture, language issues, and health literacy, and we roll it up in the term unified or, as Dennis wrote, integrated health communication. Perhaps there's something wrong with me, but I can't separate the three.

I think they're very, very interactive, and I think that's -- in terms of the future, I think we can -- hopefully, the present. I'm trying to push this, and interpreters, you know, the whole nine yards, and it comes together in provider level, institutional level. It's both structural and individual providers.

CO-CHAIR CORA-BRAMBLE: Thank you, Len. Francis?

DR. LU: Yes, this last ten minutes or so I think has been a very stimulating conversation, and I think what we're getting at here is that this work on establishing disparities measurements at such

a precise and concrete way can provide legitimacy to another yardstick, another measurement, critical measurement as part of the quality healthcare, you know, equitable care, disparities reduction.

But to really give traction, serious traction to this issue, which can be a yardstick that these various things that we've been talking about, cultural competency, health literacy, communication, language services, other things we've all mentioned here, this provides yet another yardstick that could be then translated to cost effectiveness issues that could really bring home this aspect of quality care.

So I think something like that needs to be put in this 5a section beyond what was mentioned in the next-to-the-last bullet, stimulate innovation and providing culturally sensitive care. I think that a number of things we've been talking about here really speak to that.

CO-CHAIR CORA-BRAMBLE: thank you. Yes?

MS. CUELLAR: The other thought I just had, too, that could lead to inequitable care is diminished numbers of lack of minorities in clinical research, and that indirectly might lead to some -- just to the numbers being so low, just like it is in pediatrics.

CO-CHAIR CORA-BRAMBLE: Any further comments? Yes, Colette?

DR. EDWARDS: I had a question about do we want to also explicitly put something out there to the effect that if you want to call yourself a quality provider, you need to be looking for and addressing disparities? I mean explicitly make that statement, because otherwise it's --

CO-CHAIR CORA-BRAMBLE: I think that's a good suggestion, yes. People will pass, will take a pass, yes. Any other comments? Yes, Grace, I'm sorry. I missed

it.

MS. TING: I should just put it up. So I'm actually not quite sure where this comment should go, but I would like to see as a goal a stronger tie between the measurements that we find or at least some of the measurements that we identify to the best practice recommendations that NQF had endorsed in the last couple of years.

Internally where I work, I've been struggling as to how to assign metrics to some of these best practices, and I think that without a stronger linkage there we're not going to be able to really push those best practices as quickly as I would like.

I know that we focused a lot on clinical quality measures and some of the other measurements. There are some best practices that I think could really be ripe for trying to explore some of the exploratory sentinel measures to see how we can measure those and put forth that linkage. Thanks.

CO-CHAIR CORA-BRAMBLE: Thank you. Romana?

DR. HASNAIN-WYNIA: So, I found this last 15 minutes a very interesting conversation, and in some ways, you know, we talked about under-resourced institutions really struggling to provide high quality of care. We spoke about cultural competence. I mean, you know, there are a number of issues that we brought up.

The thing that I think that really stands out for me is that when we use the language cultural competence, whether we put it in reports or we say that organizations need to focus on providing more culturally competent care, I think that what happens is that when we put that language out into the field without actually showing how to operationalize that, it becomes very, very confusing to the end users, whether they are the C-suite people, you know, the CEOs, the CMOs of hospitals or practices.

So one of the things that I would really like to see in this section, when we speak about cultural competence, maybe we should provide some key examples of what that means in practice.

So one thing in particular, and we've heard the language of navigators and community health workers, is really using a team-based approach, because I think, given that there is language in the ACA for reimbursing on team-based approach and really focusing on primary care, and it ties directly to kind of overstretched institutions and overstretched providers, especially those who are caring for vulnerable populations, I really feel that it's important for that language to be there under the umbrella of cultural competence, because you can really work with community health workers to provide care that is culturally competent.

I just have an issue with that language, because I do think that it resonates

for all of us here and for many of the people that we speak to but not necessarily out in the field. I still think you kind of get this, "Oh, that's kind of nice, but, yes, of course, we'll do that."

CO-CHAIR CORA-BRAMBLE: Agreed. So, Grace, are you -- Dennis.

CO-CHAIR ANDRULIS: I just want to respond.

CO-CHAIR CORA-BRAMBLE: Oh, go ahead.

CO-CHAIR ANDRULIS: I very much agree, but if you're going to go down that path, then it's more than that. You know, it's not just teams, or you can be a bit prescriptive or suggestive, but there is kind of a group of, extensive group of recommendations you might make. That's a solid one, but that is one of many.

DR. HASNAIN-WYNIA: And I completely agree with you, so I guess I support what you say, Dennis, but I also would

like to see explicit language about team-based care and using examples of community health workers and patient navigators and such.

CO-CHAIR CORA-BRAMBLE: Okay, Grace and then Marshall.

MS. TING: Right, and to Romana's point, maybe specifically adding language that says, you know, a part of the team should draw from the community that it serves. I think that's very critical.

And I think, Dennis, to your point, that's exactly the way that NQF has offered it in putting forth some of those best practice -- preferred -- preferred practice standards in that they did actually cite some examples of, "Here's what we mean by this particular standard," so maybe the team-based approach is certainly one, and I'm sure that we can brainstorm and generate some others as examples.

CO-CHAIR ANDRULIS: And I think if you're going to -- again, another key example

is in use of electronic health records. You know, what kind of information can be loaded in with regard to tracking and monitoring disparities and cultural competence-related language, language related to priorities?

CO-CHAIR CORA-BRAMBLE: Okay, so --

MS. TING: And Joe Bedencourt and his team have all sorts of really good languages on cultural competency that they can pull from.

CO-CHAIR CORA-BRAMBLE: So we're going to start back over here. We're going to go Marshall, Francis, and then we'll go down the other side.

DR. CHIN: So I think Romana's suggestion to be more specific about cultural competency makes a lot of sense. I think there's sort of a general caution that we need to keep in mind, also. It's also reflected in the title of this Committee, Health Disparities and Cultural Competency Consensus

Standards.

I think when we all started years ago in this area, you know, it was really sort of cultural competency, language services, I mean, really just sort of a limited number of things that we concentrated upon, whereas now I think we're realizing those are key components.

But it's much broader than that, so quality improvement, for example, or like cultural competency classes like in medical schools. I mean, the best ones are now sort of brought in to talk about disparities in which cultural competency is one component.

So I think like it's sort of woven, probably, in Joel's text, but we'll have to be careful that it comes across as this broad sort of front in terms of the solutions and attacks so that we're not in some ways trapped by our language and baggage of the past, because we have a whole range of effective policies and implementations of

which cultural competency is one component.

CO-CHAIR CORA-BRAMBLE: Okay. Francis, and then we'll start with you, Edward.

DR. LU: Again, very stimulating conversation here, and I think another target audience that the disparities measures -- this is 5a again, another bullet. Another group that we could be targeting here really are the researchers, because by providing these measures, hopefully we can stimulate researchers to use them to help measure impact, outcomes along these disparity parameters for exactly the interventions we're talking about in terms of cultural competence, literacy, and so forth.

I think these are all, I think -- you know, I think we all generally agree here that these are good things, and there has been research shown to varying extents about how this might reduce disparities, but I think that hopefully by providing these measures we

can stimulate researchers to further amplify the information that we have. So I think that's another target group.

CO-CHAIR CORA-BRAMBLE: Thank you. Edward and then Donna.

DR. HAVRANEK: There's been in the last five or ten minutes here a lot of enthusiasm expressed for things like patient navigators and increased translation services, and I'd just like to put a couple notes of caution on those very admirable recommendations.

The first is that these things are really expensive, right. It's expensive to hire a cadre of translators or to deploy translation over the phone or anything like that.

When you do that, when you hire navigators and translators to get people in to, say, colon cancer screening, some of the money you spend on those access things directly can take away from your ability to do

colonoscopies, because you can't afford a colonoscope anymore. So any calls for these sorts of things have to be tempered by the fact that there needs to either be reimbursement for it or at least acknowledgment that these things are -- we're potentially asking for unfunded mandates here.

The second thing is we have to be cognizant that these things, yes, they work, but they are imperfect solutions, right, that you could have a really good translator working with you, but you still don't provide the same quality of medical care as if you speak the patient's language, right.

It just doesn't -- that's an imperfect solution and the same with navigators. Navigators help, but, you know, there are limits to what they can do in overcoming the widespread effects of poverty and race and ethnicity and all that sort of stuff. So just a little bit of caution on these, on the enthusiasm for these.

CO-CHAIR CORA-BRAMBLE: I want to take sort of the Chair's prerogative, because I think some of the things you've raised, some of us around the table feel that there are some alternative models that are cost-effective as it relates, for instance, to interpretive services.

So I just wanted to have a few people respond to you, and, Donna, I'm just going to ask you just to hold off on your comment for a minute. I think, Liz, as soon as he said something your thing went, so I'm going to -- I'm going to interpret your body languages to mean that you have an ardent comment to share with all of us.

Everybody else who has their names up, you know, I just couldn't pass on that. It's totally subjective, but I just couldn't pass. I just couldn't pass.

DR. JACOBS: Howard, you probably don't know this about me, but I've been working for the past 12 years on looking at

the cost-effectiveness of interpreter services.

CO-CHAIR CORA-BRAMBLE: Yes, I thought so.

DR. JACOBS: So I just -- I want to let you know that I bring those years of experience to the table here, and your concerns are actually frequently expressed. Unfortunately, they're not well documented, and, actually, I've shown that they are quite small expenses of actually healthcare and do bring benefit.

In addition, when we talk about these things as unfunded mandates, people talk about the -- we forget that there are so many unfunded mandates in healthcare that we pay for, and no one complains about them.

Really, you can't ethically provide a colonoscopy or you can't reduce disparities. You can't do anything that we're talking about around this table unless you're able to adequately communicate with a patient

in a language they can understand.

So I would say that it's not really an unfunded mandate, but it's actually the only way you can actually provide the standard of care that everyone else gets in this country to someone who doesn't speak English well. It is not -- there are cost-effective ways, and Mara, I'm sure, is going to actually talk about that.

There are cost-effective ways to provide them, and they reduce other costs in terms of liability, et cetera. I'm going to let Mara go on on that, but I just wanted to let you know that if you actually do a Medline search on me you can look at some of the information about their actual costs.

CO-CHAIR CORA-BRAMBLE: So, it may be helpful for the rest of the group. I know you did some work with Hablemos Juntos and all that. Maybe you can share some of your -- some of the research regarding the cost of interpretive services. Counter argument? Is

that -- am I interpreting that correctly?

DR. HAVRANEK: Yes, absolutely. So, to say that it's cost-effective, is that from a societal perspective?

DR. JACOBS: It's from both, actually.

DR. HAVRANEK: Both. What do you mean by both? What's the other half of both?

DR. JACOBS: So there's three ways you look at cost-effectiveness, right, and you can jump in here, Joel, if you want, but society, the organization or an institutional standpoint, as well as the person.

I would say for all three of those people it's cost-effective. For all three of those standpoints, if you look at it, it's cost-effective.

CO-CHAIR CORA-BRAMBLE: Let me ask that we do this, because this is a hot button --

DR. HAVRANEK: Yes, I just -- it really is. I mean, I disagree. I just -- I

think, you know, if you were to ask hospital administrators or people who have to actually pay for this sort of stuff how they pay for it and where that money is coming out of and the disproportionate burden it places on safety net providers, I think that there would be a lot of pushback.

CO-CHAIR CORA-BRAMBLE: Let me ask that we --

DR. JACOBS: The one thing I want to say is that I think that you raise a really important point, which I think everyone around this table would agree with, is that there should be a reimbursement for those services, actually. That's one way in which we're going to actually promote the use of those services.

So I think it would -- I think that you're right that some people do perceive it as a burden. I can tell you I've done qualitative work, and Mara can talk about this, too. There are many organizations. There are --

There's Alameda Health Alliance that actually pays people to use interpreters, because they recognize their value and what it does to actually reduce their costs. I mean, so it's actually not true that all healthcare organizations actually experience this as a burden, but they see it as a value, and so I just -- so I'm just --

I mean, I think that we're probably going to agree to disagree on this point, but the point where I think we can agree is that there should be reimbursement, but I also think there is no way, absolutely no way you can reduce disparities in LEP populations without providing them services in a language that they can understand.

I mean, you can't -- we can't have any standards here on that unless that's the first step, so I'll --

CO-CHAIR CORA-BRAMBLE: Okay, so let me ask that we do this, that we just park that one for right now, and maybe we can have

a sidebar regarding this issue. I think it is a hot button issue.

I think a lot of people around the table may have done extensive work in this area, so I want to give other people the opportunity to comment, but I do think it's an important issue and one that, yes, we may have to agree to disagree, but it is critical.

So, let me start with Donna, Mara, Norman, and Grace, and then after that we're going to take a break and a deep breath. We're going to do both. Go ahead, Donna.

DR. WASHINGTON: Hopefully, my recommendation is less controversial. Though cultural competence is within the title of the Steering Committee, then other related terms are cultural sensitivity and cultural humility, and my recommendation is that whenever we're referring to cultural competent type concepts within our recommendations we instead use the term cultural sensitivity.

CO-CHAIR CORA-BRAMBLE: Okay. I

think there are -- there is an alphabet soup of cultural language that is used. I think people will -- different terms can be used, you know, health equity. There's different things, so we have to probably decide on what would be the appropriate term, but --

MS. NISHIMI: I just feel the need to chime in that notwithstanding the need to make a decision about what you want to call it, previous NQF Committees and organizationally have made decisions, so we do have full account on that.

CO-CHAIR CORA-BRAMBLE: Okay. All right. Duly noted.

MS. NISHIMI: We can expand and --

CO-CHAIR CORA-BRAMBLE: I understand. I understand. Maybe an acknowledgment that there are other terms that are used to refer to it.

MS. NISHIMI: Yes.

CO-CHAIR CORA-BRAMBLE: Acknowledged. Okay. Mara? It's you. It's

all you.

MS. YOUDELMAN: No, I know, but if we parked the last issue, maybe I shouldn't be talking about it.

CO-CHAIR CORA-BRAMBLE: Well, I think it's a hot button issue.

MS. YOUDELMAN: Okay.

CO-CHAIR CORA-BRAMBLE: I don't want to, you know, perseverate on that particular issue, because --

MS. YOUDELMAN: Well, here -- I guess I'll try to summarize it very succinctly in saying I think we do want to be very clear when we put out a report that we're not sort of giving an out to doing quality improvement because of difficulties in providing language services.

We recognize it's difficult. I agree wholeheartedly with everything that Liz said. I've been working for years with a national coalition in D.C. trying to get better reimbursement, but we're not there yet.

Ideally, obviously, if everyone could have a bicultural, bilingual healthcare provider who needed it so we didn't need interpreters and translators, that would be great, but we're not going to get there any time soon.

But I do want to be very cautious of how this is framed and that this isn't framed in a way that sort of identifies that this is a way to say, "Well, I can't do it because it's costly," or, "I can't do it because I don't have the resources," because Liz is right.

We've done a lot of work on the cost-effectiveness. We've done a report on malpractice and language barriers to show sort of the other piece of the puzzle, and so I think there is a lot of research and resources out there to help providers do this the right way.

I also think with the Affordable Care Act there's a new non-discrimination

provision that's going to go beyond what Title VI has typically done, which has applied to federal fund recipients and said, "You should be providing language services."

It's not tied to federal financial assistance, so anything created under Title I of the ACA, which is basically all of the exchanges and therefore likely the plans participating in the exchanges, are going to not be able to discriminate on the basis of race, color, national origin, disability status, age, gender.

So I think that's also -- again, it sort of reinforces what a lot of us have been doing the work on, and it's just going to continue to be that way.

CO-CHAIR CORA-BRAMBLE: Okay, thank you. Can I ask you two to put your name so that I know that we've covered you? Okay, Norman and then Grace.

DR. OTSUKA: Two quick points. I'm sorry to perseverate on the interpreter,

but I think we're all missing the point. You can talk to a patient, but if you don't understand them, there's no point having the interpreter.

I've had interpreters mess up a situation, mess up a consent. You have to understand the patient and what their goals are, and the interpreter sometimes just messes up the situation.

The other thing is Romana's point about team approach to culturally competent care. If I recall correctly, the Joint Commission sent out an announcement about two years ago that it would be part of their -- what do they call it? -- accreditation standards, so I think it's not innovative and new. We should perhaps at least look into what they wrote in their language of their announcement.

CO-CHAIR CORA-BRAMBLE: Thank you, Norman. Grace? This will be the final comment before the break.

MS. TING: Right, so I think to the point of the unfunded mandates, I think there are two points I would like to make is that, one, we need to be very cognizant that just because there's a mandate or we make the recommendation, if you don't change the fundamental workflow or how patients like Alameda County, how the patients perceive the utilization of services, you can spend millions and millions of dollars and have severe under-utilization. You don't achieve that goal, and that's just a wasted resource.

So I would say that, yes, you know, having interpreter services available is a really great first step, but if the attitude surrounding it doesn't change on the patients and there aren't infrastructural programs that change that dynamic, it's still going to be a waste of money. So from a health plan perspective, we spend millions of dollars setting up the infrastructure to deliver it, but the utilization remains virtually

nonexistent.

Then the other thing with unfunded mandates is that I think NQF and this Committee is in a really great place to really make some recommendations regarding policy changes, of changing the funding structure.

They're seeing a huge payer move towards paying for quality rather than just incidents, CMS, and then on the private side there's the patient-centered medical home and NCOs, so there is this shift that I think we can really leverage.

Two is that there is precedent for compensating providers differently, and I think my industry might dislike me for saying so, because we don't want variation in claim system. That really adds to administrative costs, but we do have these exception payments for centers of excellence, for physicians in pay-for-performance programs that we've been able to make work.

CO-CHAIR CORA-BRAMBLE: And when

you say "we," you're talking about Wellpoint.

MS. TING: Yes.

CO-CHAIR CORA-BRAMBLE: Okay.

MS. TING: And the hybrid insurance industry in general, so, you know, we have transplant centers of excellence, bariatric centers of excellence, physicians in pay-for-performance arrangements so that it could be another model for hospitals, and providers in under-represented areas might -- there could be some infrastructure that's set up to compensate them differently.

So I'm just saying that it's not without precedent, so I don't say, "Oh, we can never do that," but I think right now when there is a shift in paradigm about how we compensate for physicians and medical services. This is a great time to push some of these policy advances.

CO-CHAIR CORA-BRAMBLE: Okay, rich discussion. Joel, you're last.

DR. WEISSMAN: I know.

CO-CHAIR CORA-BRAMBLE: You're the very last one. Go for it.

DR. WEISSMAN: I am, because I have to go.

CO-CHAIR CORA-BRAMBLE: Okay.

DR. WEISSMAN: So I just wanted --

CO-CHAIR CORA-BRAMBLE: Fair enough. Fair enough. Duly noted. The floor is yours.

DR. WEISSMAN: I just wanted to thank everybody for the opportunity to come here and participate in this important exercise, and I think, you know, you all are doing great work.

I think it's going to be really interesting to come out to see how this brief is going to come out and kind of parse these issues between, you know, quality improvement and measurement and disparities at large.

I think, Denice, your point about, you know, the Medicaid differential is so important as a presumably color-blind policy

issue that disproportionately affects minorities to, you know, a huge extent. You know, you're really pushing the ball uphill when you're trying to reduce disparities and you've got this, you know, as my kids say, ginormous difference in reimbursement.

There are other kinds of social policies that are also presumably color-blind that affect mostly health disparities, health status disparities, not so much quality improvement, that the context for that would be great if you could include that in the brief. In any event, thanks again, and good luck with your report.

CO-CHAIR CORA-BRAMBLE: Let me just say one -- I think I speak on behalf of all of us. I think you did an outstanding job writing the paper, so thank you so much for that.

All right. We're going to take a ten-minute break, so we'll convene back at 10:05.

(Whereupon, the above-entitled matter went off the record at 9:54 a.m., and resumed at 10:14 a.m.)

CO-CHAIR CORA-BRAMBLE: Okay, everybody. I'm going to ask that we get started again. We are close to the finish line. This is the home stretch. I am going to let Nicole frame the discussion regarding priority and options for QI and public reporting, because this one slide summarizes the work that we still have to do. Okay, so Nicole?

MS. MCELVEEN: So, our last discussion over the past hour or so has recapped in terms of disparities measurement what we're looking to achieve. You all have given some great additions on what to avoid.

The paper also then goes through some design options, and we have touched on some of these already, but we wanted to pull this list up and just find out if there are any gaps between what's presented and maybe

additional suggestions that the group has.

If you -- if I can quickly go through these options that are listed, I don't know if folks can see that.

DR. HAVRANEK: Could you explain exception reporting?

DR. BURSTIN: So, there's often a distinction made between exceptions and exclusions. So exclusions to a measure are ones you make where you carefully delineate exactly what they are, and those patients are removed from the denominator.

Exceptions is more the post hoc analysis. As you're seeing the patient you'll go, "You know, this patient doesn't really fit," and you except them and give a reason for it. So it's more of a post hoc versus pre-exclusion.

DR. JACOBS: Quick question about this. Can we use all of them? Are we supposed to choose one? What are the -- what is the choice?

MS. NISHIMI: No, these were drawn from Joel's paper, and he just identified them as any number of design options, so the question is whether you feel some are totally inappropriate or there are others.

DR. JACOBS: So we could endorse all of them if we wanted. Okay. Thank you.

MS. NISHIMI: Yes, and they're not mutually exclusive options.

DR. JACOBS: Thank you.

CO-CHAIR CORA-BRAMBLE: Correct.

DR. JACOBS: Thank you.

CO-CHAIR CORA-BRAMBLE: Romana?

DR. HASNAIN-WYNIA: So, I just want to clarify the second one, which sounds like it's an either/or as I'm reading it, paying for performance based on lower racial or ethnic disparities versus, and I think you can do both, actually. You can show overall, you know, quality reporting and disparities reduction in reporting.

CO-CHAIR CORA-BRAMBLE: Noted.

Noted.

DR. HASNAIN-WYNIA: So I don't think it should be a versus.

CO-CHAIR CORA-BRAMBLE: So that, we need to change that. Okay. Other comments? Marshall? That's okay. Just turn on. Right.

DR. CHIN: Did anyone pick up what was meant by the second-to-last bullet about the structural characteristics? I mean, why is he singling that out here?

CO-CHAIR CORA-BRAMBLE: And there may be some question, since Joel is gone, that we may have to circle back and ask him, because I don't know that any of us are prepared to answer that, unless you are, Helen, or anyone else.

MS. TING: Actually, I was going to say -- I was going to ask a question about that, that second bullet with the versus. I wonder whether it's -- and, Marshall, maybe, or the researchers in the room can maybe

comment on this.

I wonder whether that point is about how in the past paying for just higher quality performance in general were not shown to reduce health disparities. You know, it was a case where, you know, the better performing hospitals got better and got the payment, but the lower performing hospital never really got the researchers or were able to improve, so I wonder.

It's not whether we should do one or the other. It's just that what was effective in reducing disparities and paying for quality improvement didn't have as much impact as maybe what you are proposing now, which is paying for performance on lowering the disparities specifically.

CO-CHAIR CORA-BRAMBLE: So I want Helen to clarify, and then I'm going to go around the table and let people comment.

DR. BURSTIN: I think he's referring to the issue that they brought up

yesterday of their four criteria, as well, that there's a preference for the outcome measures over process measures ultimately, but I think what he's saying here is that in terms of public reporting, for where we are right now in terms of disparities and cultural competency, structural measures may be that first step out the gate.

So proportion of patients who have access to interpreter -- no, I take that back. Does the hospital have interpreter services available, as opposed to getting to more of the process/outcome measures that get closer to what we want? I assume that's what he meant, but we can clarify with him.

CO-CHAIR CORA-BRAMBLE: Go ahead, Romana. Oh, you know what? I actually promised that we would start down there, and then we'll come back up. Go ahead, Edward.

DR. HAVRANEK: So, you know, they had presented some criteria regarding avoiding -- I think they called it cherry-picking and

lemon-dropping.

CO-CHAIR CORA-BRAMBLE: Correct.

DR. HAVRANEK: I don't see anything up there about that, so I'm wondering if there needs to be some consideration to access. So, in other words, does the -- does the organization provide appropriate access to their services to minority, racial, and ethnic minority patients?

CO-CHAIR CORA-BRAMBLE: That's a good point. I would actually prefer to keep the terms. What is it, cherry-picking and lemon-dropping? I thought that's great, great term. Next person. Mara, you had a comment?

MS. YOUDELMAN: And I don't know if it's appropriate for this piece or somewhere else in the Call for Measures, but we were talking a little bit about measures that might specifically address use of language services, use of health navigators, et cetera.

Is there a way to sort of

reference that it might not be a typical QI measure but that we also would be looking for those types of measures, as well?

I know the Speaking Together project did develop some measures for tracking collection of language data and collection of provision of language services. They didn't take in discharge, and so those might be useful as a way to expand the call for proposals to get some of those if they're relevant.

CO-CHAIR CORA-BRAMBLE: Okay. Romana, you had a -- no? Okay. Anyone else? Yes, Ernest?

DR. MOY: This just relates to the framing of this design options, which is a very generic kind of thing, and I think these kind of look like discrete separate activities that are independent from other kinds of quality improvement and public reporting activities.

I think, you know, another --

maybe that's implicit, but a better framing of it is that looking at disparities and measuring disparities should be an essential component of all quality improvement and public reporting activities --

CO-CHAIR CORA-BRAMBLE: Good point. Good point.

DR. MOY: -- as opposed to something separate, which some may say, "Oh, well, we just won't do that part of it."

CO-CHAIR CORA-BRAMBLE: Very good point. Very good point. I don't think that was brought up in the past, but I do think it's an incredibly important point that you raise. Other comments around the table?

So I am hearing that we're not going to necessarily select any of these and that we actually think that they should all stay on the list with a few additions or contextualizing a few things, but other than that the list is, we feel, comprehensive. Is there anything we're missing? Colette?

DR. EDWARDS: I don't know how this fits in, but certainly people are looking more and more in terms of incenting the patients, not just the providers.

CO-CHAIR CORA-BRAMBLE: I didn't hear the verb.

DR. EDWARDS: Incenting the patients --

CO-CHAIR CORA-BRAMBLE: Incent.

DR. EDWARDS: -- and not just the providers.

CO-CHAIR CORA-BRAMBLE: Oh, I see.

DR. EDWARDS: I didn't know if that would be a consideration.

CO-CHAIR CORA-BRAMBLE: So providing incentives either not to just the provider but also to the patient. Is that what you're saying?

DR. EDWARDS: Yes.

CO-CHAIR CORA-BRAMBLE: Okay. Any other comments, thoughts? Do you need, to the staff is the question, anything from us in

terms of fleshing those out, or is it sufficient for us to reach consensus that the list is comprehensive?

MS. NISHIMI: I think right now that's sufficient. You'll -- when there is a final report, things come back --

CO-CHAIR CORA-BRAMBLE: We'll circulate it.

MS. NISHIMI: -- around with context provided, and you'll have the opportunity then to wordsmith it.

CO-CHAIR CORA-BRAMBLE: Okay. Donna, please.

DR. WASHINGTON: For the final bullet, I would modify it to suggest risk adjusting payments to providers, rather than solely risk adjusting performance measures. As currently worded, it looks like an either/or.

CO-CHAIR CORA-BRAMBLE: I think that's probably the word of caution on several, the issue of excluding. You know,

it's either/or, as opposed to both.

DR. CHIN: Same with the first bullet.

CO-CHAIR CORA-BRAMBLE: Right. Right, and we talked about the versus, that we have to eliminate that. Anything else, any other comments?

MS. YOUDELMAN: I just have a question --

CO-CHAIR CORA-BRAMBLE: Yes?

MS. YOUDELMAN: -- because I got -- maybe I'm confused about the terminology in the last bullet. Didn't we talk about not risk adjusting performance measures? No, I know, but I thought Donna said it's read as an either/or, so the idea of risk adjusting payments rather than risk adjusting performance measures. When you were saying either/or, did you mean to add in also risk adjusting performance measures? Maybe I misunderstood.

DR. WASHINGTON: No, actually, you

picked up on, I think, what might be a wording problem. It shouldn't be risk adjusting performance measures but risk adjusting performance -- risk adjusting performance achievement.

So currently providers, like pay-for-performance, you're paid for achieving the performance measures. They're suggesting also considering risk adjusting the population risk. So the word measures should be taken out of the first sentence.

MS. YOUDELMAN: I thought -- maybe I'm just confused, but I thought that what we were talking about with Joel earlier is we don't want to sort of risk adjust within your population. You want to -- because that may mask the disparities, or maybe I'm using -- maybe the terms I'm just confusing.

I thought what he was -- am I confused as all get-out? I thought what Joel was saying is you don't want to sort of risk adjust for SES or something else. It may mask

disparities, and so is that what that's talking about, which means we shouldn't be doing it?

I'm fine with risk adjusting payments that if you have a disparity population and you need more resources to pay for language services or because folks have historically not had access and you need to give them more care. I'm fine with that. I'm just -- I don't understand the risk adjusting performance measures.

DR. WASHINGTON: Maybe one way to address it would be to substitute pay-for-performance for risk adjusting performance measures. So, in other words, I thought the recommendation in the report was to consider risk adjusting payments to providers in addition to pay-for-performance.

CO-CHAIR CORA-BRAMBLE: I think the confusion is around the term risk adjusting performance measures. I don't think it's the measures, at least the way I

understood it. I'm not sure that that's what was intended, but we can go back and seek clarity, but that to me is the question mark. We're not really risk adjusting measures.

CO-CHAIR CORA-BRAMBLE: I see. Okay. Norman, you had a comment?

DR. OTSUKA: William was first.

CO-CHAIR CORA-BRAMBLE: Oh, William is first. Okay.

DR. MCCADE: What I thought this meant was this kind of between within sort of Norman when he was describing before, and this would be like to compensate for a between phenomenon where you might more generously compensate a practitioner who cares for a minority population with respect to not trying to disadvantage people because of the measures that you might otherwise have seen with them, as opposed to risk adjusting the fact that they may have lower numbers in the performance measures that you actually see and then trying to explain that away, which would be the

description of the, I guess, within phenomenon. This is what I thought that meant. Maybe I'm wrong.

CO-CHAIR CORA-BRAMBLE: Yes, Norman?

DR. OTSUKA: Now that we talk about money and pay-for-performance, we bring this issue to a different level, and I'm wondering. We're doing pay-for-performance without giving the clinician more resources or, like you were saying, I mean, I think the first step might be to provide resources, extra reimbursement for interpreting or, you know, provide the hospital or the clinician with the resources to be able to improve their performance.

I mean, for me, in orthopedics, I guess, pay-for-performance is if you give prophylactic DVTs or if you give pre-operative antibiotics, they're easy and cuts, you know, straightforward and evidence-based and relatively easy for the clinician to do. It's

basically funded.

You know, you can give the Ancef, and it's paid for by the pharmacy, but this is a tougher mandate to do and to expect them to reach a certain level to get a one percent increase in their pay-for-performance is tough. You know, I'm on board. I'm on board with it.

CO-CHAIR CORA-BRAMBLE: No, I understand. I understand.

DR. OTSUKA: I love the principle. I just want to make it easy for the grassroots guy to be able to, so to speak, comply with this and be able to -- frankly, it's not the money, but it's being able to attain that level or that performance level that may be tough.

CO-CHAIR CORA-BRAMBLE: But I think the issue that all of this brings to the forefront is the fact that without the financial discussion, all of these things are great to have, but you have to have the

finances to be able to underwrite the work.

DR. OTSUKA: Right.

CO-CHAIR CORA-BRAMBLE: So, I hear what you're saying.

DR. OTSUKA: You know, I was being a little candid or maybe a little too -- about the interpreter in my earlier statement, but, yes, we do need them, and they're important for the infrastructure. I don't think it -- to sound -- I mean, I don't think the one percent I get for pay-for-performance would underwrite the interpreters and --

CO-CHAIR CORA-BRAMBLE: But we -- but I think the discussion also goes to a more direct payment for interpretive services.

DR. OTSUKA: Right. Right.

CO-CHAIR CORA-BRAMBLE: Not necessarily linked to pay-for performance. In other words, you know, you get the interpreter. There is a reimbursement stream that helps to underwrite that for whatever the clinic -- you know, that --

DR. OTSUKA: And then if you achieve that level, then you get your one percent or two percent.

CO-CHAIR CORA-BRAMBLE: Right, over and above, not necessarily instead of. That's the way that I'm looking at it.

DR. OTSUKA: Okay. Well, then that's -- I thank you for the clarification.

CO-CHAIR CORA-BRAMBLE: Okay. I mean, that's me. I'm a clinician like you are, so, you know, that's the way I'm looking at it.

DR. OTSUKA: I'm just thinking of all the physicians in America --

CO-CHAIR CORA-BRAMBLE: I hear you. I understand.

DR. OTSUKA: -- just trying to comply with this.

CO-CHAIR CORA-BRAMBLE: Mara?

MS. YOUDELMAN: I just, I mean, I think that's what we've been talking about is specific reimbursement for language services,

or like in an ACO model you could either have an add-on or a risk adjustment if you have an LEP population to pay either specific claims for language services or if they just want to risk adjust it and say, "You'll get X percent more if it's an LEP person," or whatever you're risk adjusting for. It hasn't been adopted yet, but that's what we've, you know, been trying to sort of talk about and think through at the policy level.

CO-CHAIR CORA-BRAMBLE: Marshall?

DR. CHIN: It may have more to do with the communication and the, I guess, the writing. We talked about like, different from a lot of prior NQF efforts, I mean, this is measurement development but then also the implementation issues.

They cannot be divorced, and right now these are lists of things. You know, there's a place for a list of things, but this is going to be narrative that needs to be more synthetic.

So, for example, the points that Norman was raising about the payments for the quality improvement infrastructure for the under-resourced settings, right now that's sort of listed as like one option up here, but that's an example of one where that probably needs to be sort of, you know, highlighted in the general company narrative, whereas some things like, you know, exclusive reporting, you know, that a list, so it's the crafting.

CO-CHAIR CORA-BRAMBLE: No, I hear you. I think there is some wordsmithing that needs to happen. I just don't know if we need to be involved in the wordsmithing, but I do agree, and we need to -- you know, the, I think, staff needs to decide where they're going to put this, as opposed to a laundry list, and that sort of -- that needs to happen, but I don't know that we need to be involved in that.

DR. OTSUKA: There are a lot of other hidden costs, obviously, diet. I mean,

I shouldn't say this out loud, but I keep patients extra time because of their religious beliefs. They can't be discharged at a certain time. You know, I mean, there are so many, a multitude of hidden costs, you know.

CO-CHAIR CORA-BRAMBLE: Any other comments from the group regarding this list? See, we can reach consensus. Okay, go ahead.

MS. MCELVEEN: And so taking into account what we've talked about just now and then as well as in Section 4 with some of the methodological issues, we just wanted to kind of go through public reporting for disparities and talking about how that should be used.

So, for example, should it be used for payment and reimbursement purposes for consumer choice? Should it be used to motivate providers to improve performance? Again, we may have touched on some of these topics already, so if you have any additional comments.

CO-CHAIR CORA-BRAMBLE: Romana, go

ahead.

DR. HASNAIN-WYNIA: So I'm curious about or I'd like to hear thoughts about the motivating providers to improve performance, because, you know, when we talk about public reports, I think the first thing that comes to mind are public reports for the public, but, again, I'm going to use my aligning forces for quality experience to highlight what's taking place in 17 markets throughout the United States where there is a strong focus on public reporting.

So the providers are not necessarily publicly reporting all of their measures publicly, especially the disparities measures, mostly because they don't have the race, ethnicity, and language data right now to do that.

But even as they do go forward with their kind of initial public reports, they are reporting them internally within their, you know, within their professions,

basically, which has a place in motivating performance, kind of being accountable to your profession.

So when we're talking about public reports here, I think we do need to delineate whether we're talking about public reports for the public or whether we're talking about public reports for, you know, practices or medical groups, whether we're talking about individual provider reports. Are we talking about --

CO-CHAIR CORA-BRAMBLE: That's a good point.

DR. HASNAIN-WYNIA: -- disaggregating them or not?

CO-CHAIR CORA-BRAMBLE: Very good point. I don't know that we had addressed that explicitly, but I agree with you that it's a good point, and I do know that some of those that are collecting data, oftentimes it's shared internally, and it doesn't even make it to their website, so I do understand

what you're saying.

Marshall, did you have a comment? You have to turn your card around so I can see it. Go ahead.

MS. WU: So, a couple things with regards to Romana's point. I have actually sat on a lot of quality data reporting advisory committees that tried to get to the consumer, and it's really hard, really super hard.

People are bending over backwards to make it consumer friendly and, you know, how they can search and stars and happy faces and all that kind of stuff, and it just doesn't seem to quite work. It doesn't, so I think there's still --

CO-CHAIR CORA-BRAMBLE: What is it that's so hard about it, for those of us who have not been involved in that process?

MS. WU: I'm not sure our healthcare market is set up for being driven by consumer choice. You know, the comparison

is like the coffee shop.

When you have three coffee shops in a couple blocks and you can go, and there's price and quality versus going to a website and looking at all this medical data and trying to make sense of it for yourself and then making a choice with your provider in a health plan, and even understanding that difference I think is hard. Our healthcare system is very complicated.

So I think there is -- that transparency and public reporting are absolutely critical. There are consumer advocates, navigators, other kind of middle people who can probably help with that interpretation.

I just would caution doing the public reporting for the consumer's sake just because it's a lot of work. It's a lot of effort, and I'm not sure how much it yields, and I'm a consumer advocate, but I think it --

CO-CHAIR CORA-BRAMBLE: So

different levels of reporting, and I think the observation that was made is that we really haven't discussed that there are multiple levels. That may be sort of the ultimate, but there are still a few others that are interim levels that I think, you know, their work --

MS. WU: That are really important.

CO-CHAIR CORA-BRAMBLE: Right, they're important in terms of, you know, motivating providers to improve quality of care. That's one of the things that we do in our clinics, and it's very effective. It's very powerful when you share the data.

MS. WU: So the second thing is I think there's a really great opportunity here where the ACAs and the exchanges are coming up and running, because I know for each of the state and federal, at the federal level, the exchanges have to determine how health plans are certified to qualify to play in the exchange.

I think quality data and certainly equity issues would be great to be added into that, and we could work fast enough to get ahead of that curve for when the exchanges become operational in 2014.

CO-CHAIR CORA-BRAMBLE: Thank you. Marshall?

DR. CHIN: Yes, in terms of that last bullet, I think it's probably all of the above. It's basically, you know, money, as well as then for public reporting to different audiences.

I remember very early on the first day -- it may have been Ellen. I can't remember -- someone made the point that even the things that are designed for consumers, the mechanism probably is not the consumer comes the power.

It's really because providers realize it's the public, and so they have to act, and they're a large purchaser type of consumer, so in some ways it doesn't matter,

probably, because once the data is out there, it's out there, but it does apply to all of those different mechanisms. I think it was the report that said, "Well, here's the list of potential mechanisms."

CO-CHAIR CORA-BRAMBLE: Thank you. Luther?

DR. CLARK: I'm not sure this fits in the first item there, but I was wondering is there a role here for professional societies and organizations, because they develop guidelines and registries, and that information is often reported, and if they can be included in the loop, that would seem to be a very helpful thing to do.

CO-CHAIR CORA-BRAMBLE: Dennis?

CO-CHAIR ANDRULIS: I just wanted to add. Perhaps it kind of picks up a little bit on what the troublemaker over here, Elizabeth, raised.

CO-CHAIR CORA-BRAMBLE: Troublemaker? Excuse me, Co-Chair. I don't

think that's language you use in this Committee.

CO-CHAIR ANDRULIS: Oh, that's right. I'm supposed to be --

CO-CHAIR CORA-BRAMBLE: Please excuse him, Liz.

CO-CHAIR ANDRULIS: Politic. That is the politic preference.

DR. JACOBS: When people stop calling me a troublemaker, I'll be upset.

CO-CHAIR ANDRULIS: But it refers back to a point, actually, Elizabeth and I talked about, too, a little bit in the break, and that is whether there is another purpose that should be recognized here around assisting providers who are caring for large numbers of minority patients, safety net providers in particular.

I don't know whether you want to mention safety nets specifically but whether there is an opportunity to use that information or for that information to be

considered in the context of those organizations that those providers that are offering care to large numbers.

I don't see it specifically in there. I see it for reimbursement purposes, but I don't see it recognized in the context of assistance, considering resource needs, resource starved or those who need additional resources.

CO-CHAIR CORA-BRAMBLE: Also, I wanted to come back to what you were saying, Luther. I actually think that's an excellent point in terms of professional societies, and I don't know that we addressed it at any point before, so I think it's -- I just wanted to highlight it that I think that's an excellent suggestion.

Other comments? Francis?

DR. LU: Yes, I would just second that in terms of the professional organizations. I sit on the Executive Committee of the Practice Guidelines for the

American Psychiatric Association, and I think that it would be wonderful if we could include some of these disparity measurements as part of our practice guidelines, and perhaps there are other organizations, as well.

CO-CHAIR CORA-BRAMBLE: Other comments? Some of these societies and associations are actually making steps. You know, they're already going towards that, you know, but this would help. I think this would be very -- I sit on the Board of the Academic Pediatric Association, and I think that would be instrumental. Other comments?

MS. MCELVEEN: Great. So, this really concludes our discussion about the paper as a whole. I know we opened it up for any additional comments, but, again, if you have any additional comments, questions, now is the time to talk about them. We're going to now transition to framing our Call for Measures around disparities, so are there any -- Marshall?

DR. CHIN: I'll get back to what I mentioned about Carolyn Chancy at a meeting like this saying, "Well, don't forget the big picture." We've mentioned maybe two or three times, most recently, I guess, Francis, but I think one of the big ones is this point about equity measures aren't a separate thing, that they really are something that all organizations need to consider in all of their quality efforts.

So we do have some disparity-specific measures, but in some ways those are the gross minority of the different things, and so that frame in the overall document needs to be a critical one so that it doesn't become sort of a relatively small percentage of what different organizations do.

CO-CHAIR CORA-BRAMBLE: Colette, did you have a comment?

DR. EDWARDS: This goes back to the conversation that we were having about the language used with regard to cultural

competency, and I don't now, Robyn, that maybe this has already been hashed out, as you said, in some other committee in terms of do we want to think about using minorities versus something else.

CO-CHAIR CORA-BRAMBLE: I'll defer to the NQF staff.

MS. NISHIMI: Yes, it really has. That's a term that actually came out of the first work. If there are -- I think there are ways to craft why we use this term, you know, "And by this we mean," and then if you had other verbiage you'd like to suggest around it, but to make this sort of a whole scale reversal of terminology I think is really not --

CO-CHAIR CORA-BRAMBLE: I think, though, it is helpful to note that in some places in the U.S. the minorities are really not minorities anymore, so just so that the reader understands --

MS. NISHIMI: Right.

CO-CHAIR CORA-BRAMBLE: -- that, you know, we know that.

MS. NISHIMI: Right, and so that's what I meant, yes, exactly, that kind of sort of framing in explanatory language but to sort of replace that construct for another construct I think would be not really a good idea at this time.

CO-CHAIR CORA-BRAMBLE: Okay. Noted. Comments? Yes.

MS. WU: Actually, I wanted to add on to that, and I'm glad Colette brought it up, because I know mainly in California when we talk about it, we talk about communities of color, and we're 60 percent majority minority, so it feels like it's hopefully starting to be an outdated term that hopefully we can shift to a better descriptive.

CO-CHAIR CORA-BRAMBLE: That's a good point. I do. I think that it's a good observation, and it's always tough to read guidelines and recommendations that a

committee has reached consensus on that seem devoid from reality, and I want to make sure that to the degree that our name is going to be on it that it's grounded.

Other comments from anyone else? Yes? I'm sorry, I didn't see you.

DR. MOY: Again, a more generic kind of comment, which is I don't know if there's a need in this document somewhere to try to make the case what are the social goods of disparities. Why do we care about it other than for the disparate populations and the providers that take care of it?

So, you know, what are the implications for society of dealing with these issues of disparities? There are obviously the issues of inequities and trying to achieve a fair society and other arguments, I think, that have been put forward, though, for why people who are not members of disparate groups or providers should care or that sometimes we can look at disparities as the canary in the

mine, and that is a lot of the problems with healthcare often are first detected through issues of disparities.

So, for instance, we had the conversation about language, and so, yes, obviously, you can't counsel somebody if they don't understand the language you speak. I think that's led to the broader conversation about health literacy for English speakers. They can't understand you, either.

So that's, you know, a translation from disparities to a general quality improvement kind of benefit for all of society. I don't know if we have to articulate that or if NQF simply assumes disparities reduction and measurement is good.

CO-CHAIR CORA-BRAMBLE: No, I think your point is well taken. I do.

CO-CHAIR ANDRULIS: Again, I think this comes back to context for the report, that issues around employment, employer base, the diverse workforce that is growing in our

society, the recognition that even though you may think you're not going to be affected that there are not only the canary in the coal mine, but you've got conditions like panflu.

If you can just ground it a bit more, I guess, is what we're talking about here in a real live context, I think that will add kind of a life and a resonance to other audiences, broader audiences to pick up on what you're saying.

CO-CHAIR CORA-BRAMBLE: Liz?

DR. JACOBS: Oh, just to follow up on what Ernie said, I think people don't realize that, actually, disparities cost us in so many ways, right, because we're actually dedicating resources to taking care of patients who are sicker.

Ron Anderson makes this great argument, you know, like if you look at trauma centers, and if we're not doing things -- you know, all of us are disadvantaged if we can't get into a trauma center, and if minorities

are disproportionately there and we're not doing things to prevent it, then we also miss out on that resource. So if you want to speak to people's self-interest, I think that's another way to do it.

CO-CHAIR CORA-BRAMBLE: Good point. Any other comments? Joel has his card up, and so he's going to speak in absentia over there. Any -- I hear you. I hear you. Did you have a comment? Yours is up. No? No. Anything else? Comments from any of the participants on the phone? I don't know if their lines are muted or not.

MS. MCELVEEN: Operator, can you open the lines on the phone?

OPERATOR: All lines are open.

CO-CHAIR CORA-BRAMBLE: Any comments from the phone participants? Okay. I pass on a consensus baton to you.

MS. MCELVEEN: Okay. So, next we're going to talk about framing our Call for Measures, and so there are several documents

that we've provided to the group to help think this through. Two are examples of previous Call for Measures. One should be on care coordination, and the other would be on child health.

The third packet of information that we've provided you with is a rather lengthy document, which is our online measure submission form, and so we're not going to go through that entire form, but we really wanted to just provide that example to you so you have an idea of what we ask for in terms of submitting standards for consideration.

So, first I'd like to go through the examples provided to the group, the two examples on the Call for Measures, and briefly when we do a Call for Measures, obviously there is some contextual information around the background of the project, but the meat of that call is really around specifically the types of measures you're looking for and any sub-topics.

So some just examples that I pulled that we put in the past are, you know, specifying that we're looking for measures on patient-reported outcomes or we're looking for measures that address healthcare utilization. In addition, we do want to be specific around the areas that should be addressed.

So some examples that I pulled were measures to evaluate the capacity of primary care and specialty care, measures to address care coordination for patients with comorbidities. So it leaves the room for the Committee to come up with as much specificity as you all think is appropriate.

One thing I also wanted to note, if you're looking at the Call for Measures around child health outcomes, that Committee actually crafted that Call for Measures, and one important point to note is they really sort of pushed the envelope in terms of requesting measures around public health.

You know, that's really a new area

for NQF, and we don't have very many measures around there, so they really pushed the envelope and put it out there. Not surprisingly, we got some very, very good measures that really addressed the key issues that they highlighted.

So you all as a group have that authority and really that capacity to ask for the measures that you're looking for. It doesn't mean we'll get them all in, but I think putting it out there for measure developers to be aware of what's important for disparities and what we're ultimately looking for is where we want to go.

I have also the cultural competency framework. I think you all highlighted some great suggestions for addressing cultural competency for measurement. I just wanted to pull up this framework.

This is from the NQF project on cultural competency. This is the framework

that we endorsed, and so I just wanted to highlight the domains within that framework, but I think, again, you all touched a lot on some areas around cultural competency, so we won't prolong on that.

Then, finally, just recapping some of my notes from yesterday, we did get some recommendations on measures thus far, and we did get a few more today, as well. The ones that I have noted are it's important that we get measures around system and structural measures for capturing disparities.

Again, we'll need some more clarity to help flesh out that idea, but that's something that came out at the meeting yesterday, as well as cross-cutting measures that are really applicable for all populations. So those were the two that rose to the top.

There were some more mentioned today, and I can -- it was measures around, again, language services, which was heard loud

and clear, and also patients' use of navigation services. Those are the two that I have in my notes today.

So now is the time to open up the discussion again for being a little more detailed about the ideas that I have up there and providing some additional recommendations.

DR. CHIN: Can we use the white boards?

MS. MCELVEEN: Yes.

CO-CHAIR CORA-BRAMBLE: Okay. The floor is open. We'll start off with you at the end.

DR. O'BRIEN: Can we have something to start with in terms of the text that was circulated with getting this Committee together? Do we have basically a title of what this is about with just some language just to look at?

CO-CHAIR CORA-BRAMBLE: I think this is all we have. I don't think there is anything else other -- well, she did. She

gave examples of child health and care coordination. I think that for those of us who have never drafted measures, it may be we may need a little bit more, so let's -- Francis, go ahead.

DR. LU: On the page 51 of the report, I think there are some additional suggestions in this area.

MS. MCELVEEN: Yes, that's a great starting point, Francis. If we want to start on page 51 from the report, they provide some suggestions on what measures should be selected. We can use that maybe as a starting point with the group.

DR. O'BRIEN: Yes, I just think that delineating the scope is a really important part of it and trying to figure out how broad to be, but in order to get this group together, we received an email saying, "Hey, we're getting a group together to do something." What was it that the NQF staff wrote to us and invited us to or had a call to

have a Steering Committee for?

CO-CHAIR CORA-BRAMBLE: I mean, we did the task, which is basically the consensus regarding, you know, the work that we did. I don't understand what you're asking for. Help me understand it. Yes, Romana?

DR. HASNAIN-WYNIA: So, if I'm understanding what Sean is saying, when the call went out, for example, when the call went out from NQF to nominate and to convene this Committee, there were certain specifications in that.

You know, there were certain objectives of what the role of this Committee would be, what we were charged to do, so drawing from that as a starting point, as well, to kind of frame the overall objective that may potentially, you know, make its way into the introductory language here, but it gives us somewhat of kind of an umbrella or a conceptual framing of why we're all here, and then we can start, you know, delving into the

weeds.

MS. WU: Well, what about the -- what about the slides that were used for the conference call, some of those?

CO-CHAIR CORA-BRAMBLE: They're looking. Just give them a few minutes. They're trying to retrieve that. Other comments? Edward, did you have a comment while we're waiting?

DR. HAVRANEK: Oh, yes. I'm sorry. I just wanted to add to the list that whole idea of access. Is there a way to include as a quality measure a measure of whether or not the organization adequately cares for minorities that are in its catchment area or in its local population?

Again, the idea is that, you know, one way to make your disparities go away is to not let a certain number of people in the door or a certain type of person in the door, and so I just want to be really sure that we don't promote that by asking for a performance

measure that looks at access.

CO-CHAIR CORA-BRAMBLE: Ellen?

MS. WU: Can I -- I'm going over some measures, and I just --

CO-CHAIR CORA-BRAMBLE: Sure, go ahead.

MS. WU: So I really -- I have my notes on page 51 -- really like the health-related quality of life measures idea. I know that there are some developed for pediatrics, and I'm not sure if there are for general, but it would be great to get some of those.

Then what was the slide that was up before in terms of systems measures, I think there are a lot of different elements that could be under that. Certainly, one is IT system and the ability to collect the information but also what to do with it and all the IT.

There's probably national work, but there is also a statewide in California an IT consumer collaborative where we've outlined

some principles which probably we could draw upon to fill that in, and then I know there's other --

I don't know. Mara would probably have to help me out. I forget the different groups that have talked, kind of tried to define what cultural competency is and how to operationalize it within an internal system like diversity of staff within the healthcare system, the leadership team, the training that happens from kind of member orientation within the system. So think those are already outlined somewhere.

MS. YOUDELMAN: Well, the Joint --

CO-CHAIR CORA-BRAMBLE: Go ahead and make your comment.

MS. YOUDELMAN: I was going to say the Joint Commission, when it developed its new hospital accreditation standards for cultural competence in patient-centered care and effective communication, which a number of us were involved in the development of that,

we put out a roadmap that has a lot of recommendations and additional resources for hospitals but really for anyone on sort of implementing all of these different pieces of the puzzle.

CO-CHAIR ANDRULIS: Yes, this is -- this is, I think, a good place to talk about cross-referencing to other resources. Again, I think Mara's point is really well taken if you look at what Tawara Goode has done in this area.

Some of the areas you're talking about are echoed in our cultural competence assessment protocol, where you look at leadership and workforce diversity and community outreach and IT and business strategies.

There are fields that are -- that were prioritized by and looked at by organizations as areas that they should be concentrating on, at least structurally, but then you could use and match with and

encourage the matching of effectiveness measures, patient satisfaction with some of the structural measures, as well.

[Off-mic comment]

CO-CHAIR CORA-BRAMBLE: I wanted to go back to something that -- oh, Ellen, did you have another comment? I wanted to go back to something that Ed had said regarding access and to take it to another level.

For some of the community providers, particularly subspecialists, that simply say, "We don't accept Medicaid patients," that's sort of a way of cherry-picking and lemon-dropping so that, you know, their outcomes would probably be good because of the fact that they're not accepting those that are most at risk.

I don't know how we can craft something in terms of measures that specifically alludes to that. I don't know if it's a social responsibility to accept those sorts of -- I don't know how we -- the

language we would use, but I think that excluding Medicaid populations from, you know, different providers' panel is an easy way to reach a certain level of quality of care.

Other comments? I don't see cards up. Y'all are getting quiet on me in the last hours. Come on. Marshall?

DR. CHIN: Just a process question to make sure we understand the task. So the past day and a half we've gone through a number of measures, existing measures that Joel and Joe have these three categories.

There were like these 700 measures with a subset related to disparities. They had a second category where maybe disparities weren't evident, but they still are possible, and they're part of the existing 700.

So this is now the third component, where we're asked to come up with what are the different potential domains which don't exist in any of the 700 existing NQF measures that we then have this RFA to ask

developers to submit actual questions or measures that then have been validated.

So this is to fill in that particular gap, and these measures are for what purpose, then? These are for like public reporting and --

CO-CHAIR CORA-BRAMBLE: Helen?

DR. BURSTIN: The full range of accountability functions, whether that's public reporting, pay-for-performance, whatever that case may be.

DR. CHIN: So the audience is going to be largely big players in terms of health insurers and --

DR. BURSTIN: Yes, I mean, these should be measures that he'll feel comfortable are validated, could be used for comparison across providers, things like that, yes, not necessarily just the internal QI ones but really ones that rise to the level of feeling like they've met a threshold, and you'd feel comfortable comparing Provider A to Provider

B.

DR. CHIN: And the assumption is that these are areas where basically they don't -- well, it may be a good assumption. I was going to say the assumption is that these measures don't exist, so people are going to be developing them or else they already exist, and now people are proposing them.

DR. BURSTIN: I think our hope is -- we've given a time line for this. It's the latter, but, then again, there may be that -- part of what we also do as part of these efforts is we signal to the field where measure development is needed.

We recognize that's not going to happen in the next few months before this Call for Measures goes out, so in this case we're really saying, "Those of you out there who have got a measure that you've worked with that you think could be brought in, please bring it forward to NQF."

DR. CHIN: This issue that either

Sean or Ed brought up earlier that some measures may be validated for majority populations but may not have been tested in minority populations, and so what qualifies for that in terms of being a measure that is able to be submitted, then? In other words, it has to be validated upon a minority population or just validated in some population?

DR. BURSTIN: It's really a question, Marshall, if anybody else wants to jump in. I think that, in general, if it's a measure that includes the patient voice, like a survey, we would very much expect that the populations who would be completing it would be tested.

I think for a measure that looks at outcomes of heart disease or whatever the case may be, we don't have an expectation necessarily that you would provide that data, although, again, if it's a measure already in our portfolio that's up for maintenance and a

full review again, we would expect to see those stratified results back to us.

MS. NISHIMI: And if I could just add, at the end of the day, when NQF receives that information, you know, at some level I think, and Helen can correct me if I'm wrong, but if the Committee feels that, you know, it's otherwise a very good and solid measure, has some testing data in populations that you're not entirely satisfied with, you know, that's something that you could think about whether or not it meets the threshold to at least move over and be further considered.

CO-CHAIR CORA-BRAMBLE: Norman and then Liz.

DR. OTSUKA: I mentioned it earlier, but there should be some measure about education for academic centers and their adherence to some of the ACGME guidelines or core competencies or their commitment to teaching culturally competent care to their residents and medical students.

The other -- another point, you asked about providers, how much of their profile would be private pay versus non-private pay. I guess it's all geographic. I mean, if a physician is in a place where it's 90 percent non-private and their profile is 90 percent private insurers, I mean, there is some disparity there.

CO-CHAIR CORA-BRAMBLE: But right now that's not kept in check. In other words, in the District of Columbia, which is still, you know, predominantly African-American -- well, let me put it this -- it's a transition, but there is still a sizeable African-American population.

There are providers in the District who refuse to see Medicaid patients, and I'm not talking about just a few. I'm talking about the majority of providers in certain subspecialty areas --

DR. OTSUKA: So that --

CO-CHAIR CORA-BRAMBLE: -- refuse

to see Medicaid patients.

DR. OTSUKA: So that physician's profile would not be in keeping with the geographic area.

CO-CHAIR CORA-BRAMBLE: Correct, but right now it doesn't matter. It's up to the provider to make that choice.

DR. OTSUKA: Right, so I guess there's no real way to compare.

CO-CHAIR CORA-BRAMBLE: Correct. Exactly, but then they may be eligible for, you know, added payments for X. If they don't have that sort of at-risk population that requires additional resources, yes, they're likely to reach that benchmark much quicker.

DR. OTSUKA: My measure fails then.

CO-CHAIR CORA-BRAMBLE: Yes.

DR. OTSUKA: Okay.

DR. JACOBS: Oh, just to follow up on what Norman said, and this goes under systems, is actually looking at whether

organizations do training around how to care for patients from different backgrounds, cultural competency or however you want to call it.

I know the Joint Commission has some actual language around it. I mean, we should -- we can look at some of their standards that they proposed, I think, as things that we could develop measures around, actually.

CO-CHAIR CORA-BRAMBLE: You know, my suggest is that we also look at use as much as has been developed that is relevant to this work, you know, the class standards. There are other -- people have spent hours and hours, and some of these Committee members may have been a part of those Committees, so let's not reinvent the wheel would be my suggestion.

DR. OTSUKA: So, I'm sorry, I guess the infrastructure, a measure of the infrastructure that exists, I mean, interpreters --

CO-CHAIR CORA-BRAMBLE: Yes.

DR. JACOBS: Also the training that they give.

DR. OTSUKA: And the training to nurses, et cetera.

DR. JACOBS: Right. Right, so in addition to residents.

CO-CHAIR CORA-BRAMBLE: I'm going to go to this side of the table now for a minute. Okay, Romana, you speak, and then we'll take all of these other folks on the right side.

DR. HASNAIN-WYNIA: Just in terms of resources, and this is for the NQF staff, but the Ethical Force Program for the American Medical Association put out a report on communication with multiple patient populations.

They actually developed a number of domains, but most importantly, under those domains such as engaging the community workforce, collecting data, evaluating

performance, health literacy, many of the things that we've talked about today, at the end of each chapter there are a list of suggested performance measures for organizations. So that might be a starting point. I just pulled it up.

CO-CHAIR CORA-BRAMBLE: Give me the name again.

DR. HASNAIN-WYNIA: Yes, the name of the report, and it's available online, and you guys --

CO-CHAIR CORA-BRAMBLE: Okay, just for the rest of us, because we don't --

DR. HASNAIN-WYNIA: It's "Improving Communication, Improving Care: How Healthcare Organizations Can Ensure Effective Patient-Centered Communication With People from Diverse Populations."

CO-CHAIR CORA-BRAMBLE: And the organization that published it is?

DR. HASNAIN-WYNIA: It's the American Medical Association.

CO-CHAIR CORA-BRAMBLE: Oh, AMA. Okay.

DR. HASNAIN-WYNIA: Yes, Ethical Force Program, but --

CO-CHAIR CORA-BRAMBLE: Got it. That's the disclosure, right? There you go.

DR. HASNAIN-WYNIA: But it's the -- the piece that's important in that is that at the end of each chapter it has the performance evaluation.

CO-CHAIR CORA-BRAMBLE: Their performance measures. Got it.

DR. HASNAIN-WYNIA: Performance measures, right.

CO-CHAIR CORA-BRAMBLE: Okay. All right. We'll start right here with Ernest, and then we'll work out way down. Go ahead.

DR. MOY: Okay, so I think this is kind of topical areas related to this reducing disparities that we haven't kind of covered so far, right. One area that we could include specifically are patient perceptions and

experiences of bias in healthcare settings, something I don't think we've talked about so far, and there is some science there.

CO-CHAIR CORA-BRAMBLE: Okay. Thank you, and there has been -- yes, there's published literature as it relates to that. Francis?

DR. LU: In terms of the wording of the call, I think it might be helpful to, if we all agree with this, number 5 on page 51 if we would agree to endorse the 35 ambulatory disparity-sensitive measures. That could be referenced as like examples for people to look at in terms of, you know, in terms of how -- to help people with the process of submission.

CO-CHAIR CORA-BRAMBLE: Okay. Thank you. Colette?

DR. EDWARDS: My comment had to do with the comment that you made in terms of let's not reinvent the wheel for things that are already specifically disparities-related, but do we want to also think about things that

aren't specific to disparities but are high priority like readmission that Medicare is focusing on where we know that disparities do exist?

CO-CHAIR CORA-BRAMBLE: I see. Okay. Good point. Mary?

DR. MARYLAND: I'd ask two things, that we think about education in terms of training the next generations, that we would look at these issues in relationship to health professions and hospital administration and all the folks who will be making these decisions in the future.

How do we include this? And, as we move forward, are there ways to reference what's important in the ACA that this might directly impact as we have full implementation?

CO-CHAIR CORA-BRAMBLE: Go ahead, Dennis. That actually was a comment to what Mary is saying, because otherwise you're going to have to wait until everybody else talks.

I promised -- I promised my esteemed colleagues on the right side of the table that we would go in line, and then we come back, unless it's a comment. Not a comment?

All right. There you go. It is a comment. I'd better let him talk. Let me let him talk, okay, and then, you know, there you go. Go ahead.

CO-CHAIR ANDRULIS: I want to build on, I think, previous comments about looking at what the actual calling form has put on in terms of priority areas. There is a care coordination piece that I think might serve as a piece for, I think, us and NQF to reflect on, because care coordination is such a huge, huge issue with regard to the priority populations we're talking about.

So I think this piece in particular may be worthwhile looking at as a priority area, building on what you were saying, Colette, about what you would select

out as kind of greater than in some ways.

CO-CHAIR CORA-BRAMBLE: Okay.

DR. CHIN: So I think a big umbrella category to include specifically is medical home concepts for multiple populations, because within that there's going to be like a set of like six to eight different domains that cut across a lot of things we're talking about, across to communication, care coordination, communication with external providers, tracking and monitoring of patients, quality improvement, shared decision-making, et cetera.

This would be medical home concepts both patient measures, so, for example, NCQA how has a medical home CAPS that's going to enter the field very soon, as well as an organizational measure. It's going to be organizational structure measures.

But if you start getting into that literature and you have a writeup, that's

going to cover a lot of things we've talked about, and then it should resonate, because these things are being done more broadly, but for vulnerable populations, then there's less out there in terms of instruments which have the tailoring for a lot of the populations we're talking about.

CO-CHAIR ANDRULIS: I agree with the importance of medical home. I think I wouldn't want it to be an umbrella piece, because by the nature of the way services are going to be rendered, I mean, medical home is maybe a goal, not the nature of the way services are going to evolve.

DR. CHIN: Maybe I misspoke. Maybe the thing is to -- maybe medical home is listed but then specifically going back and then pulling out like the eight different traditional domains that are used. Like if you look at the current NCQA domains for medical home, they've got six to eight or so that are the ones we're talking about.

MS. CUELLAR: -- care coordination. I was also thinking about the diversity of particularly systems of leadership and of the actual staff providing the care and also the development and use of community advisory groups that come directly from the population.

CO-CHAIR CORA-BRAMBLE: Thank you. Next?

MS. WU: I'm just -- she mentioned the community input, the process to get community engagement and input.

CO-CHAIR CORA-BRAMBLE: Thanks. For those who already spoke, Francis and Lourdes, just put your name tags down so that I know you're done. Sean?

DR. O'BRIEN: Well, I hope I'm not changing focus or derailing, and just let me know if I'm going in a direction that you don't want to go, but I've been just thinking about what are the components that I think need to be in a Call for Measures and that

maybe would be discussed.

There's some just basic issues of scope, and I don't know if anything requires discussion or not, but it's basically there's lots of groups you could focus on, but it sounds like this group is focusing specifically on race, ethnicity, and low English proficiency, and that's it. Would that go in the Call for Measures? Basically, that's the scope of this particular activity.

CO-CHAIR CORA-BRAMBLE: You know, it's a point well taken, because, I mean, as I go around the country speaking about cultural competence, you know, that's one issue that is oftentimes raised. It's like, "Well, what about the physically disabled or challenged, or what about the gay and lesbian?"

You know, so I think it's a point of discussion. We may get that pushback from the field once this goes out as to what -- and if it is exclusively focused on language or

race or ethnicity, then it needs to be so stated. She says yes.

DR. O'BRIEN: Another one is that --

CO-CHAIR CORA-BRAMBLE: Before you continue, perhaps it would be helpful to at least, whatever report we submit, that it states that we acknowledge that diversity includes other things beyond race and ethnicity, but the task of this group was focused exclusively in that area. Okay.

DR. O'BRIEN: Another big on with NQF, all the measures are required to be suitable for public reporting, and that is something that some measures may or may be less amenable with the public reporting versus internal quality improvement, but if that's a requirement from the NQF, that probably should be highlighted in the Call for Measures, because it probably would make a difference in terms of which measures would be approved or not.

DR. BURSTIN: All of our Calls for Measures make it explicit what the purpose of NQF addressed measures are, and it is really broadly accountability, not just public reporting, so pay-for-performance, whatever the case may be.

DR. O'BRIEN: And -

CO-CHAIR CORA-BRAMBLE: Go ahead. Finish.

DR. O'BRIEN: And then some statement about the level, the unit, the level of reporting, and I'm sure that would be in there, too, but are there any so, you know, individual practitioners, community hospitals, plans, national --

CO-CHAIR CORA-BRAMBLE: Right, and we touched on that.

DR. O'BRIEN: Is it all of the above, including kind of the national population level reporting, as well? That's the kind of thing includes the AHRQ, National Disparities Report. Is there anything you'd

like take off the table?

DR. BURSTIN: Yes, it's another really good point. We are happy to accept population health level measures, as long as there's a comparison group, so a national would be kind of hard unless you're looking at international.

But certainly we've taken it in as part of the Child Health Project, for example, Medicaid state program measures compared to each other, things along those lines, but I think it will be important in the project in particular to elucidate what levels of analysis we're referring to.

CO-CHAIR CORA-BRAMBLE: Thank you. Good observations, Sean, good questions. I know you were trying to probe, you know, but it raised some important issues that we needed to clarify. Any other comments? Nicole?

MS. MCELVEEN: Okay. Okay. Thank you. We got several recommendations from the group on that, so that was very helpful, and

so the next piece that I wanted to touch on, again, we reviewed this a little bit yesterday, and that's NQF's approach moving forward for addressing disparities.

Before we kind of dive into that, I wanted to highlight to the group within our measure submission form, which is that thicker document that you all have, where we request information around disparities, and maybe use that as a starting point and see if, you know, the group agrees with that approach. Certainly feel free to provide some additional suggestions.

So that's kind of a thick packet, and I'll also pull it up on -- so the pages aren't numbered, but, you know, I'll let you know which pages I'm referring to.

So, to provide some background and context, the first kind of two pages really talk about the conditions that must be met for the measure to even be considered by NQF. Again, you know, this is with all of our

measures. The measure has to be in the public domain or measure steward agreement has to be signed.

Again, as we just mentioned, it has to be intended for both public reporting and quality improvement. The measure does have to be fully specified and tested, and also we do request that the measure developer address harmonization and issues around related measures, related or competing measures.

So, moving on, if you go to page four of that packet, that section then focuses on the specifications of the measure, so we get into the meat of the measure, the description, the numerator, denominator.

So, on page four, it's Section DE-5. You'll see there's -- and this is just a check box area for them to first identify if they choose to do so that the measure is addressing disparities, as well as some additional cross-cutting areas that are

highlighted in that section.

Then, moving on to page five, that section 2a1-5, you'll see the target population category. We do also then provide an opportunity for the measure developer to specify whether or not that target population is disparity-sensitive or not.

DR. JACOBS: So would the form change for this process, or it would be the standard form that people would use, and you would ask them to check these boxes?

MS. MCELVEEN: It would be the standard form.

DR. JACOBS: Okay.

DR. BURSTIN: But I think part of the bigger picture for us is as we look forward towards updating these forms, which you'd do probably annually, the idea being what else based on our discussions would you ask about disparities to ask the submitters to submit the information you think would be valuable.

DR. JACOBS: Okay. Thank you.

DR. BURSTIN: We could also do supplemental requests for these specific measures as you need to.

MS. MCELVEEN: Moving on through the form, if you all go to page eight -- yes? Sorry. Question? Sorry.

DR. O'BRIEN: Well, I mean, we can come back to it. I was just going to ask. I mean, I'm looking at the numerator and denominator as the form is laid out for the specifications. My question is does that work? Does that format work for all the types of measures that may be on the table?

For example, if you identify a disparity population and the goal is to basically measure improvement for some particular end point or process in that population, sure, a numerator and denominator works.

Are there any measures where the actual focus of the measure is measuring the

quantifying disparity, which implies a comparison between two populations? In that case, you have -- you don't just have a simple numerator and denominator anymore, but I don't know to what extent those are the types of measures that will be submitted.

DR. BURSTIN: Accept attachments or whatever we need if it doesn't quite fit in the box. We actually even revised the submission form for the recent project we just did on research use measures, because they don't fit this box at all, so if we need to do that, we can do that for this project, as well.

CO-CHAIR CORA-BRAMBLE: Any other comments? Francis? Francis first and then Ernest.

DR. LU: Yes, this is for -- there's no page numbers, but it says, "Subject Topic Areas," and, again, this might be the standard NQF --

CO-CHAIR CORA-BRAMBLE: Towards

the beginning or the end of the document?

DR. LU: This is -- this is the fourth page in.

CO-CHAIR CORA-BRAMBLE: Okay.

DR. LU: It says, "Subject Topic Areas," and, again, this might be standardized and there's no changing it, but I'm just wondering about having mental health be like mental health/substance abuse to include that.

CO-CHAIR CORA-BRAMBLE: We want to make it two different ones.

DR. LU: Slash.

CO-CHAIR CORA-BRAMBLE: We've got it. Okay. Ernest?

DR. MOY: I think this group has created a more formal definition of disparity-sensitive than previously existed, so I was wondering if you wanted to include that definition in the form someplace and also possibly have a check-off box about what qualifies as disparity-sensitive. Is it because it has a much higher prevalence in a

particular group --

CO-CHAIR CORA-BRAMBLE: Yes, good point. Excellent point.

DR. MOY: -- in any group or a particular --

CO-CHAIR CORA-BRAMBLE: Very, very good point. Liz? Oh, I'm sorry, then Sean. Go ahead. Go ahead, Liz.

DR. JACOBS: Just to follow up on that, disparities means a lot of things to different people, and I notice it just says disparities. For instance, I don't think a lot of people think of language groups as a disparities population. They think, "Oh, black, white, Latino, white," so I think that maybe adding some definition or some more detail around that would be helpful.

DR. BURSTIN: There actually are definitions.

DR. JACOBS: Oh, there are? Okay. We just don't see it.

CO-CHAIR CORA-BRAMBLE: Was it

Sean? Okay. Other comments? Excellent suggestions and comments, really. Anyone else? Yes, William, please?

DR. MCCADE: Looking at that same group of topics or subject areas, some things kind of can't really be broken down in the organ systems, I guess. So, for instance, pain, for instance, is a disparity. It isn't listed as an organ system. It's not there, and that might be something that one might want to look at.

CO-CHAIR CORA-BRAMBLE: Excellent point. Yes?

DR. OTSUKA: Under subjects I see musculoskeletal. Thank you, but what about children or pediatrics? I don't see them.

DR. BURSTIN: It's below it.

DR. OTSUKA: Is it?

DR. BURSTIN: It allows you to choose by condition, cross-cutting area, and then population, so we can capture both, yes.

DR. OTSUKA: All right. Thank

you.

CO-CHAIR CORA-BRAMBLE: Come on, give us some credit for the musculoskeletal. I mean, come on. We messed up the first time. We got it this time.

DR. OTSUKA: Children's important, too.

CO-CHAIR CORA-BRAMBLE: Donna? Did you -- okay. All right, so Donna and then Liz.

DR. WASHINGTON: Yes, there are some categories on the form that we want to discourage. So, for example, it asks about risk adjustment type, and I wonder if people developing or submitting performance measures might take that to mean that they should risk adjust when, in fact, we would like to discourage that.

CO-CHAIR CORA-BRAMBLE: Okay. Liz?

DR. JACOBS: Yes, I notice there's a section called "Importance," and it says,

"Demonstrate a high-impact aspect of healthcare," and I wonder if we want to say reducing disparities. Oh, I'm sorry. I don't know the page number.

CO-CHAIR CORA-BRAMBLE: Towards the beginning, towards the end?

DR. JACOBS: One, two, three, four, five, six, seven, eight. It's right after care setting, level of analysis, importance, 1(a)1.

CO-CHAIR CORA-BRAMBLE: Okay.

DR. JACOBS: I wonder if reducing disparities --

CO-CHAIR CORA-BRAMBLE: Oh, the reason, yes.

DR. JACOBS: -- or something along those lines.

MS. MCELVEEN: That's actually the next section I was going to mention where we talk about disparities, so thank you, Liz. It's a little bit further down under importance.

We do ask for a summary of the data on disparities by the population group and also citations to support that, so if there are some more suggestions on how we can capture that information or if you all think that's sufficient, and this is under importance.

The other thing I should mention is importance is a threshold criterion. It's important that they demonstrate, you know, the opportunity for quality improvement and really provide the evidence to support that. So this is a section that when these measures come in the group will weigh very heavily on, so we want to make sure we're asking the appropriate questions.

CO-CHAIR CORA-BRAMBLE: Go ahead, William.

DR. MCCADE: I just flipped to the next page. I'm looking at the quantity of studies, the body of evidence. This is 1(c)5, and it asks for total number of studies, not

articles, and the question in that regard is since this is still an evolving and relatively new field and disparities are just being identified and different new technologies, is that really a valid sort of question that you still want to put in for this particular analysis of development of metrics?

DR. BURSTIN: Most of this form is for our standard, all of the measures that come forward to us, and the Evidence Task Force recently did some work identifying, at least for now, the approaches to look at the quality of the -- too much cold medicine -- quality, quantity, and consistency of the evidence, so they'll weigh all three of those.

So at times there will be one very good high-quality study but not a whole lot of volume of studies, and that's okay as long as it's consistent. So I don't know that we need to get into the weeds of all the specifics. We would be here for days, as our committees often are, but it's a good point about

disparities, and we can --

CO-CHAIR CORA-BRAMBLE: I have two that are eager to go, Marshall and Dennis. You all decide.

MS. NISHIMI: Just to interject more to Helen's point, too, the Committee will see the submission form that comes in, and they may see only one study, so I think it's a valid thing to ask, because then you will assess the input and decide for yourselves whether that's important, being consistent or not.

CO-CHAIR CORA-BRAMBLE: Okay.

DR. CHIN: Following up on Bill's point that, you know, you look at something like, well, diabetes measures. There's tons and tons of studies, so it's easy to fill out the form.

I think a disparities measurement person looking at this form would say, there's no way in hell I'm going to get it approved. There's going to be a lot of blanks or no

evidence.

So I'm wondering does there need to be -- well, first, you know, is it an absolute, because if it is, then we're going to get no measures that we're going to be approving, but if there is a lower bar, in a sense, in some ways we have to send that message out that you don't necessarily have to, you know.

CO-CHAIR CORA-BRAMBLE: Yes.

DR. CHIN: Otherwise, people are going to say you're not ready for primetime.

CO-CHAIR ANDRULIS: Yes, I want to build on both these comments, too, that this is an opportunity to push the field a bit. My sense is it's push and refine the field.

You know, I think the field could benefit from this level of specificity, seeing it, seeing what is required, but at the same time to exclude or to so limit because literature may not be available or some folks will just throw up their hands, they've got

some good ideas.

So, whether it be part of this process or in addition to this process, it seems it may be worthwhile for us to consider is there a way to advise NQF in terms of still encouraging some submissions that may not qualify or meet minimum, at least the minimum set of criteria, but will at the same time, be setting a course, you know, as a collective body of information for where the field needs to go. I think that's where you'll get into some of these other areas that have not been touched on.

DR. BURSTIN: Remember, this is the Steering Committee that's going to review those measures, so it's you guys. It's not like you're passing this information on to somebody else.

It's actually these measures in the next phase come to you, so you'll have a chance to reflect on all this, and maybe that -- we have had discussion about in these sort

of emerging measurement areas can we have some discretion, and we can indicate that that's possible.

I think the concern has been in some areas that are more clinical, sometimes they may see emerging in terms of quality measurement. There's a whole lot of evidence there. This is really emerging in terms of what the evidence base is, which I think is a little different.

CO-CHAIR CORA-BRAMBLE: Francis and then William.

DR. LU: Yes, just reiterating what Dennis and Helen just said, I think this touches into that area of the emerging measures, and I think that needs to be kind of highlighted in the up-front call in order to encourage more of these emerging measures. I think this may be a little different than some of the other NQF calls.

CO-CHAIR CORA-BRAMBLE: Agreed, yes. William?

DR. McCADE: So I don't know whether each one of the Calls for Measures comes with an FAQ, but I know they're very useful for program directors in ACGME to have FAQs about most every statement that we put into a program requirement.

So I'm thinking that if there isn't such a vehicle, maybe we should think about doing that so that we enable people who are going to write these things to have additional information and explanation and maybe also to allow us to justify ourselves in the use of certain language that we talked about already such as minority or other sorts of phrases and the types of nature of disparities that we're talking about.

CO-CHAIR CORA-BRAMBLE: Okay. Any other comments?

MS. MCELVEEN: So, just to quickly recap, it seems like the group is okay with how disparities is mentioned underneath our importance section. Is that right? Okay.

DR. JACOBS: I would say, I mean, I don't know how this is going to be written, but it says demonstrate a high impact of healthcare. Shouldn't there be a box on disparities? I mean, am I --

DR. BURSTIN: Again, you're only seeing this form. There's actually a lot of underlying definitions that go with it that specifically tie high impact to the National Quality Strategy, of which disparities is front and center.

DR. JACOBS: Oh, okay.

DR. BURSTIN: So they're automatically in --

DR. JACOBS: Okay, thank you.

DR. BURSTIN: -- in some ways on impact.

DR. JACOBS: Thank you. Thank you. Thank you.

CO-CHAIR CORA-BRAMBLE: This actually makes it a bit hard to give you comments when there are so many other layers

that we don't see.

DR. BURSTIN: I thought we were just going to focus on just the elements regarding the comparison.

CO-CHAIR CORA-BRAMBLE: I believe -- that's what I'm saying. We don't want to give you superficial comments, and you all are already in the weeks.

DR. JACOBS: I just want to follow up on what Marshall said, because I put my card down, but he said exactly what I wanted to say. Are we going to add some modification of language around the evidence part?

DR. BURSTIN: We'll try to write something up, and we'll share it with you.

DR. JACOBS: Thank you.

MS. MCELVEEN: And, lastly, the third section in which we mention disparities is under scientific acceptability, so let me give you that page. That section starts on page 11, and it's page 14, Section 2c-1, and the scientific acceptability is essentially

the section that talks about reliability, validity, and provides a lot of the information around testing for the measure.

So you see disparities in care. There's two basic questions, if the measure is stratified for disparities and to provide the results for that, and also if disparities have been reported or identified but the measure is not specified to detect those disparities.

So are there any comments first around those two specific questions?

DR. JACOBS: What does that mean, 2c-2? It's not specified? I mean, if you look and they're there, so I'm a little bit unclear on that.

DR. BURSTIN: Will actually come forward to us with strata, for example, saying, "This is the measure. These are the strata you should examine," and not many do, so this is really just a point to them like, "Okay, you haven't said it should be stratified."

Early on, I believe there's also a question about evidence. We may have skipped over that. If there's evidence there are known disparities in this area, okay, you said there is known evidence of disparities. You haven't presented a measure with strata.

DR. JACOBS: I see. Got it.

DR. BURSTIN: We struggle with these questions, and we find we don't get very good answers back, which is why we actually want to get better advice from you guys.

Based on the discussion you've had for the last two days, what are the right questions to ask measure developers as they submit measures to us, whether they're the cross-cutting deposition measures or just any measures that you want to be able to get at the issues you guys talked about yesterday?

DR. O'BRIEN: Can there be -- can this form be customized for each Steering Committee and each activity, or is it you need to stick with one?

DR. BURSTIN: It's possible. We've done it for resource use when the entire thing just didn't fit into this box at all. We could always add an addendum or whatever we need to do or specify, but, yes.

The problem is you're just looking at the paper form. It's actually an online submission tool, so it's not as easy to just kind of delete, change, whatever, but we can make it work.

MS. NISHIMI: I think the other thing to keep in mind is that some of what's being identified here can also be fit into the call, so it's both a give and take. People see the call, and then they call and say, "Yo, we can't figure out where this fits in your form," and the staff, you know --

CO-CHAIR CORA-BRAMBLE: I have two comments, one from William and one from Liz. Who else? Oh, I'm sorry. Donna? Oh, my goodness. Wait a minute. Hold on. Hold on. Let's start with Donna. We'll go all the way

around the table. Why don't we do that? Donna?

DR. WASHINGTON: Sure, just to raise the risk adjustment issue again, then in this section 2b-4.4, then it asks the submitters to justify lack of adjustment, so it seems as if this section, if the form can't be modified, then some instruction should be included.

CO-CHAIR CORA-BRAMBLE: Liz, then Grace. Oh, let me see. Romana, you're next and then Liz.

DR. HASNAIN-WYNIA: I'm not sure whether this is a concern, but when I first saw the heading here on scientific acceptability, and I might be wearing my researcher hat right now, but I'm worried that as, you know, as the people who look at this for submitting measures see that section, what I'm wondering is whether we need to have language, because, you know, I saw that, and the first thing that jumps to mind, and maybe

it's because it's just because I've been having these conversations, is I think about scientific acceptability.

I start thinking about randomized control trials. There aren't very many. There's a lot of pre-post. There are a lot of comparison group. There's, you know, seeing improvement within the same group.

So I don't know whether we need to, you know, again, in terms of our language and what our expectations are in this particular section, because soon as I saw that, I started to think, "Oh, would somebody see this and think, 'We don't fall into that bucket, because'" --

DR. BURSTIN: And, just to be clear, it's actually scientific acceptability of the measurement properties. It's not the whole thing.

DR. HASNAIN-WYNIA: Right, so maybe we should -- right. No, that's what I mean, though. I'm just talking about kind of

what jumped out at me initially, so if that's the kind of intent, then I think we need to make sure that that is right there.

CO-CHAIR CORA-BRAMBLE: Liz and then Grace.

DR. JACOBS: So, I'm wondering if 2c-1 should be present stratified results based on our conversation, and then, instead of if measured to stratify, then say, "If not stratified, justify why." I mean, sometimes people may not stratify, because the groups are too small.

CO-CHAIR CORA-BRAMBLE: Good suggestion.

DR. JACOBS: So maybe the gold standard should be is it stratified, and then they have to justify why they're not.

CO-CHAIR CORA-BRAMBLE: Yes. Good suggestion. William and then, Sean, didn't you have yours up? You changed your mind? Trying to confuse me. William, go ahead.

DR. MCCADE: I don't understand

the actual value of 2c-2, and I would just eliminate it from our particular call just because the measures that we're trying to call for are ones that are specifically designed to detect disparities. Is that not correct?

CO-CHAIR CORA-BRAMBLE: Good point. Other comments?

MS. TING: This is more of a question, and I may have seen this, but after the NQF reviews all of the 700, and let's say you come up with hopefully just 30 or 40, who's going to be filling out the form for those measures and submitting them?

MS. NISHIMI: They've already been endorsed.

MS. TING: Oh, okay, I see that. Okay.

MS. NISHIMI: You guys know this. They split them up.

MS. TING: I'm sorry, more questions. So how is that going to be expressed so that people won't submit

duplicate to those? Is that going to be shared when you release the call of, "Here's what we're thinking of already"?

MS. NISHIMI: Yes, I think that as part of the call we ask people to review what's already endorsed in NQF's portfolio, so that's sort of SOP, I think, and then staff would understand, which is not to stop someone from --

CO-CHAIR CORA-BRAMBLE: Resubmitting.

MS. NISHIMI: -- resubmitting, but --

MS. TING: But, wait, so like I would not want to go through 700 standards to figure out which ones I should, so if you already now down a list, you can say, "Here are the ones that we" --

CO-CHAIR CORA-BRAMBLE: Right, that relate to disparities, right, to make it easier.

MS. NISHIMI: I think that, at the

end of the day, folks make their decision to submit or not submit based on sort of the face value of the call, because the fact of the matter is we're not going to be able to winnow down the 700 and release that list. First you all have to review that in time for the call to occur.

CO-CHAIR CORA-BRAMBLE: Any other comments?

MS. FITZGERALD: This is Dawn on the telephone.

CO-CHAIR CORA-BRAMBLE: Okay. Sure.

MS. FITZGERALD: Actually, I'm a little bit confused on that last statement about the requirements for resubmission of measures. So if I have, let's say, any one of the HEDIS measures, for example, could resubmit for disparity sensitivity. Is then the change in that measure the sense that there would be then required to have stratification of that measure?

DR. BURSTIN: No, there would be no requirement to resubmit a measure for disparity sensitivity, although I think it does bring up the question -- I think Ernie raised this yesterday -- of whether we need to actually as part of the submission indicate those criteria we're actually listing out for disparity sensitivity as one consideration.

MS. FITZGERALD: I get the sense that if we don't put the parameters around it, everybody would simply resubmit measures.

MS. NISHIMI: I mean, I think what the call would indicate is that measures that have already been endorsed are already being reviewed, so it's not that they have to resubmit it. If there is a HEDIS measure that didn't get endorsed and has never been submitted, then, yes, that would have to be submitted.

CO-CHAIR CORA-BRAMBLE: Yes. Okay. Other questions, comments?

DR. BURSTIN: One more

consideration for you. I mean, you guys are all so steeped in disparities. You think about this a lot.

Think about measures and, you know, this kind of forum going to the renal committee that's meeting in a couple of weeks at NQF. What would you want to make sure they have that they're going to want to get the information from that will kind of raise some flags for them?

Part of the issue is it's not always going to be folks who are pretty steeped in disparities. They'll oftentimes be clinicians, evidence-based medicine folks, statisticians -- no offense, Sean -- who have this sort of bigger picture of the measurements side that may not bring the disparities lens to the table.

That's kind of what we were hoping to get, to see if there's something else we should ask here that would be useful. I thought there was a question on evidence base,

as well, isn't there?

DR. CHIN: What's an example of what you're thinking about?

DR. BURSTIN: So the question would be we just had a committee that reviewed all the ESRD measures, so a whole slew of the ESRD measures they reviewed. Some they took. Some they didn't like, but there was not a whole lot of discussion through the course of the Steering Committee that said, "Boy, we know these are areas where there are known disparities. Which of these measures should be stratified?"

So part of this is to sort of get into their thinking as they're prospectively reviewing measures. How do they think about the disparities piece?

So, you know, we've had minimal questions here to date. They haven't been terribly useful except when a measure is now up for maintenance, where we have been making it very clear you can't resubmit a measure to

us for additional endorsement without that stratified data at your three-year point, but particularly for new measures that are coming to us, what would you want the Committee to know about that measure or consider about the populations for whom the measure is important?

CO-CHAIR CORA-BRAMBLE: Do you want to respond to that, Sean?

DR. O'BRIEN: No, I wasn't responding, and maybe I --

CO-CHAIR CORA-BRAMBLE: You had your name tag up.

DR. O'BRIEN: I did.

CO-CHAIR CORA-BRAMBLE: Okay, go ahead.

DR. O'BRIEN: Well, I mean, yes, I really -- I guess I would agree, and my past experience is what you put on the form probably has a lot to do with what you get in the submission, and you can -- I don't know. I would maybe think about taking this form and having somebody take a really go at going

through it and coming up with a customized version of it.

I mean, there's some that's in there has to be in here, because there's basically previous NQF work that's established a framework, and things need to fit into that framework, but in my experience helping people fill out these forms and actually looking at them as a reviewer is you can make -- you can try to make things fit into an existing form if you have to, but that leads to people who are confused about, "Well, how does this sentence here really fit in this context?"

The more you have that's confusing to the people who are submitting the measures, it's not going to do us any good, and so it may seem like too much detail to spend more time on this, but this up-front work of trying to really figure out what needs to be asked and revising this I think would pay off.

CO-CHAIR CORA-BRAMBLE: I have Francis and then Romana.

DR. LU: Since this area may be quite new to many people, because disparities reduction, you know, is such an emerging concept by itself, and as we've been talking about the last couple of days and as all we know, I'm just wondering, for example could the Harvard-commissioned paper, if that's --

At some point within the public domain, could that be linked to this call so that people can kind of read the background about what this is all about and understand where we're coming from and what the priorities are being here, racial, ethnic, minorities, and language?

That's kind of the -- I mean, even -- because I think the better -- the more we can specify this in a reasoned way and provide the background rationales and all of this, it will reduce, hopefully -- it will help the submitters, because they'll know more precisely what we're looking for and are thinking, and also it will help us, the

reviewers, because we'll have better submissions with more information and someone to help us to figure things out, because otherwise it will be kind of garbage in-garbage out, I'm afraid.

CO-CHAIR CORA-BRAMBLE: Romana and then Mary.

DR. HASNAIN-WYNIA: Helen, I actually wanted to --

CO-CHAIR CORA-BRAMBLE: I mean Donna. I'm sorry.

DR. HASNAIN-WYNIA: I wanted to ask you about kind of so you used the end state renal disease folks as the example. So basically what I'm trying to understand is what are, you know, what are they going to get?

Let's just take that example through. So will that Committee, for example, provide measures for us? I'm trying to understand where in the process we are trying to inform them, because that is very hazy to

me.

DR. BURSTIN: Okay. That's good. I think I'm just too inside a baseball.

DR. CHIN: As opposed to having people like us on that Committee or people like them on this Committee.

DR. BURSTIN: Right, exactly, and they are a blend of all of you, and we actually do try to make sure there's disparities expertise around the table. I think the idea would be that it wouldn't come back to you, per se.

The idea would be what do you want every single committee at NQF to look at, regardless of the topic area, whether it's cross-cutting care coordination, whether it's ESRD or heart disease or palliative care or prenatal care in the coming year. What do you want every single one of those committees as they're reviewing these measures to think about, to want to know from the measure developers about is there evidence of

disparities in this given area, you know, provide stratified data?

It's just really kind of high-level thinking that you want to make sure they all at least go through that process. As much as they look at reliability, they look at validity.

Again, it's the point we tried to make with the NHQR and the DR, that we put the same quality measures on the DR intentionally to make the case that we weren't marginalizing disparities. I think the question is how do you make it front and center in what they're doing in a way that makes sense.

DR. HASNAIN-WYNIA: So, can I follow up?

CO-CHAIR CORA-BRAMBLE: Follow up, and then we have Mary and then Donna.

DR. HASNAIN-WYNIA: Okay, so the -- so I guess my question then is is this the document, what those committees are? The document that they get is this one.

DR. BURSTIN: Yes, is this form, and they evaluate the measures based on this form and our criteria.

DR. HASNAIN-WYNIA: Okay, so I like the idea of attaching the report, but that, you know, is a 100-plus page report.

CO-CHAIR CORA-BRAMBLE: Maybe the Executive Summary.

DR. HASNAIN-WYNIA: The Executive Summary might, but I also think how we frame this up front is going to be -- is really going to drive that, I mean, really setting that stage in that up front, you know, the front end piece of this document. So we are -- I think you said we are going to all get a chance to review that and comment on that, right?

CO-CHAIR CORA-BRAMBLE: I do believe.

DR. HASNAIN-WYNIA: Okay.

CO-CHAIR CORA-BRAMBLE: So, Mary, Donna, then Liz.

DR. MARYLAND: So part of the answer, I think, in relationship to ESRD and any other disease process is the question, "Is there a differential that should be considered that may be attributed to race, ethnicity, et cetera?"

So, when you look at ESRD, is there something in this packet that says, "Have we considered whether the person should be a transplant candidate? Yes/No. Have we considered whether or not they have a satisfactory English proficiency to be a satisfactory candidate for transplant? Yes/No."

So what is it that guides us to believe that no matter the area, we have asked that critical question that there has not been automatic reflects of exclusion based on race-ethnicity.

CO-CHAIR CORA-BRAMBLE: Okay, so Donna, Liz, Ernest, and Colette.

DR. WASHINGTON: So, along those

lines, to address Helen's question on the importance, the demonstrated high-impact aspect of healthcare, maybe that's a place to specifically clarify that it could affect large numbers of minorities.

So, for example, if you had a very small, numerically small minority population that was disproportionately affected by a certain condition that did not affect the overall population, that may not necessarily qualify the way the form is currently written.

CO-CHAIR CORA-BRAMBLE: Liz?

DR. JACOBS: My comment is really brief. Following up on what Romana said about the Executive Summary, I actually found the Executive Summary -- I didn't understand it until I read the report, so it would just have to be a little bit more fleshed out, actually. I think it would be extremely useful. It just needs a little work, and we can give them feedback on that if that would be helpful.

DR. MOY: Okay. It seems to me

that this is actually a moderate change in the NQF processes to introduce this new disparities concept, and I think I'm concerned that the way disparities are currently spread out all across the form it's not going to get a lot of focus.

If you're -- if this is important enough that you're going to give them this Executive Summary for a new review methodology that you might want to pull the disparities piece out as a separate section that someone is going to formally review it for consideration for disparities.

CO-CHAIR ANDRULIS: Colette?

DR. EDWARDS: I guess my question is do we feel as if this area is important enough that -- I don't know what the language would be that would be used, but if it actually fell into the NQF conditions section that sends the message loud and clear of the importance of that and it goes across the board for the committees who are reviewing

measures and for the people filling out the form that you have to have thought about this before you do any type of submission. It may be that whatever you're submitting may or may not have something that's disparities-related, but you have to have done some analysis to answer that question.

CO-CHAIR CORA-BRAMBLE: Luther?

DR. CLARK: I actually have a question. Maybe it's for the group, but it's in response to Helen's question in terms of what would we like to be present in all of these documents or on these metrics.

My question, can anyone think of a surrogate marker for a disparity that would allow you to detect it, you know, a measure of all the things that we're doing that if you see it there, then this is a marker that there is a disparity?

It's a pretty complicated field with a lot of different parts, but if there was some signal or clue that it's there that

we could measure easily, then that would be very, very helpful. I don't know. We have a lot of thinkers around the table, so it's just something you've thought about.

CO-CHAIR CORA-BRAMBLE: It's notable that I don't see a whole lot of cards going up. Your question just -- there was just not -- there you go. Sean.

DR. O'BRIEN: No, I'm not giving the answer, just a follow-up question. Do we have a definition of disparity that we're using?

CO-CHAIR CORA-BRAMBLE: I assume that we do.

CO-CHAIR ANDRULIS: IOM.

DR. O'BRIEN: So IOM has that part in it that are not related to access. I mean, one of the things it excludes is access-related factors. Is that really consistent with what everyone here is thinking?

CO-CHAIR CORA-BRAMBLE: Oh, I see what you're saying. Liz? Oh, Liz and then

Mary. Go ahead.

DR. JACOBS: I actually noted that, too, the access, and I was wondering why that was, because maybe everyone has access to healthcare, but there are other forms of access within the healthcare system, so I'm wondering if we want to think about how we want to define that.

CO-CHAIR CORA-BRAMBLE: That's a good point. Mary, and then I want to see if anybody has an answer for Luther.

DR. MARYLAND: And so I'm going t take a stab at it. Is it that the answer is always retrospective and in the unequal outcome?

CO-CHAIR CORA-BRAMBLE: He's not moved.

DR. CLARK: I think that would be in retrospect, so I think that, you know, something that would allow us to detect it prospectively, because once it's there, I think that this group will be clear that it's

there, but it's a thought. It may not exist, but if it did, it could simplify a lot of what we're trying to do.

CO-CHAIR CORA-BRAMBLE: I agree. If it did exist, it would simplify. Romana?

DR. HASNAIN-WYNIA: I'm sorry. I just don't understand the question. Maybe I'm --

CO-CHAIR CORA-BRAMBLE: Is there a hemoglobin A1c for diabetes? Is there something comparable, if I understand you correctly? It's oversimplistic, but that's sort of the gist of it. Is there a marker?

DR. JACOBS: Mortality, but that you can't measure, I mean.

CO-CHAIR CORA-BRAMBLE: Right. I mean, it's -- we have a lot of thinkers around this table, and I don't see -- as I said, it's --

DR. HASNAIN-WYNIA: I definitely don't think there is one, just because, I mean, I think one of the conversations that

we're having shows, I mean, is evident of that and also the fact that it's so multi-factorial.

CO-CHAIR CORA-BRAMBLE: Correct.

DR. HASNAIN-WYNIA: You know, the underlying causes of disparities are so multi-factorial.

CO-CHAIR CORA-BRAMBLE: Agreed. Agreed. Any other comments?

DR. CHIN: It took me a while to sort of put this thing in my head, but now I see why Helen keeps on getting -- she's been subtly bringing this up across the meeting about this point about how can we influence the other committees.

So I wonder if we can spend a little bit more time talking about it. Maybe give a little more context, Helen, in terms of our brainstorming, because this is actually probably as important if not more than what we're doing in terms of how it's going to actually disseminate across, I guess, the

overall measures.

DR. BURSTIN: Right, so maybe I'll give an example which actually might help. So cardiovascular disease, a long history of known disparities.

God knows half of us in the room have written about the disparities in cardiovascular disease, I think, and yet, you know, these measures all come to the Committee. They reviewed 65 measures, all the current cardiovascular measures in inpatient, outpatient, nursing homes, everywhere all together in one bucket.

You know, if you look at what comes in, nothing was really heavily stratified, or there wasn't a strong orientation to disparities, and it really came down to the Chair of the Committee, Ray Gibbons, who is the Chair of cardiology at Mayo, who just said, "Stop. Half these forms that are measures that have been endorsed for three years have no data on disparities.

Disparities is a well known area in cardiovascular disease. I will not review these measures until somebody gets me some stratified data."

I'm like in the back of the room, and, you know, the question is how do we kind of put it front and center? Really, I think Ernie is absolutely right. If this is a sea change and we are trying to make people think about this for all measures prospectively going forward, what do you want them to think about?

What do you want to make sure they put front and center as they review any quality measure as it relates to disparity populations so that you can -- and I think the point here would be if these measures didn't get picked up by CMS or others, as they frequently do for all these various accountability functions, do we ultimately start pushing to making sure that they're stratified, that that stratified information

becomes part of that public reporting?

I just -- I think it's a path towards, I think, where many of us would like to go, and I just want to -- I'm trying to think about what steps we take on our end to help push that.

CO-CHAIR CORA-BRAMBLE: So Norman.

DR. OTSUKA: I mean, briefly, if I could provide you with the model of the American Academy of Orthopedic Surgeons, various committees have business plans where they ask the Board for money, but all those plans have to go through our Diversity Advisory Board, and they have a checklist of three questions.

Is there an effect on diversity or healthcare? I mean, does it involve healthcare disparities, and if it does, how does it? If it doesn't, no.

So my point to you is all of our business plans go through our committee, so maybe sort of a form or a way to sort of

review all these measures, and I don't know how many measures go through the NQF, but there's probably a few dozen, three dozen business plans that go through the American Academy that our committee reviews, so just a thought, just a different model.

CO-CHAIR CORA-BRAMBLE: Thank you. Edward?

DR. HAVRANEK: I was just going to say, just to echo what you've already said, which is that when other disease-specific groups look at measures that they have -- that they are requiring themselves that they look at data on whether or not disparities exist, that would be the one thing.

The second thing that I would add is, and this is a theme that has come up again and again, is will this measure have a disproportionate effect on institutions that disproportionately care for disparity populations?

So, you know, I think that that is

-- that there are frequently unintended consequences on disparities via effects on disparity serving -- institutions that serve disparate populations or populations with disparities. So those are the two questions, or that would be the two hurdles I would ask them to jump over.

CO-CHAIR CORA-BRAMBLE: William and the Mary.

DR. MCCADE: I was actually thinking that's where Norm was headed when he was getting ready to speak, before he spoke. I only add to Edward's comment that not just institutions but providers of information of all types who would be adversely impacted by this particular standard when you're invoking a new metric.

CO-CHAIR CORA-BRAMBLE: Mary then Marshall then Liz. I got it down now.

DR. MARYLAND: One consideration is to make it a non-optional opt-out, rather an opt-in, so that could solve the problem and

very stringent criteria to meet in opting out.

CO-CHAIR CORA-BRAMBLE: Marshall then Liz.

DR. CHIN: Some of this is brainstorming, but, I mean, just bringing together some of the things people have already said, so if there is a separate section called disparities, maybe just a preamble, you know, disparities, equity is a critical component of all the quality efforts. Do your -- the stratification of the measures, the existing measures.

This is also an issue in terms of the documentation, but then there is also thinking about are there measures which help you elucidate mechanism, I guess, and so potentially asking about, "Well, do you have measures that -- I think most of them will be measures that document disparities, per se, in terms of the process or the outcome, but something about which of your measures help us understand the underlying causes of the

disparities or somehow sort of getting at that angle. That's a little bit different here.

CO-CHAIR CORA-BRAMBLE: Okay. Liz and then --

DR. JACOBS: Yes, so to follow up on this conversation that Helen and Edward are having, I think it depends on how we're talking about using these measures, because, again, we talked about how should these measures be used if we're actually going to use them to actually provide more resources to people to see if they can reduce disparities.

It's not penalizing them. It's actually identifying the problem that we're going to help solve, so I think it all also lies in --

Following up on what Marshall said, I mean, it's good to see can we look at what are some of the root causes, but also is there a way to actually, you know, not see this as penalizing people or punitive -- excuse me. That's the word I'm looking for.

CO-CHAIR CORA-BRAMBLE: Romana?

DR. HASNAIN-WYNIA: So, Marshall, are you basically saying that we should really focus on asking for not just the documentation of, you know, there's a disparity in this process measure or disparities in this outcome but asking for kind of what the underlying, potential underlying cause of the disparity, the reason for the disparity, not just the documentation of the disparity?

DR. CHIN: No, I misspoke. It's probably mostly like a process measure that helps you understand etiology. So a sample like -- this is not a good example, but like just a care coordination process measure that helps understand why follow-up is poor at ESRD listed or something like that, so trying to get them to think beyond the usual suspects in terms of the measures.

Again, this is all sort of -- I can't articulate it well, but I think it just gets at a different angle than probably like

most of the measures that are already there.

CO-CHAIR CORA-BRAMBLE: Liz, did you still have something to say? No? Okay. Anyone else, any other comments? Marcella?

DR. NUNEZ-SMITH: Oh, okay, so I just had one follow-up to -- Sean and Liz were both talking about the IOM definition, so we might just need language around specifying when we talk about access, it's sort of, you know, the IOM I think is referring sort of access to a healthcare system, and maybe we're thinking about access within the healthcare system around some of the measures or the stats such as language access.

So it's probably important, because I think there are many people who might see if we're using the IOM definition and automatically, again, step away, and so just maybe a proposition definition to say access within healthcare and give an example might be helpful.

CO-CHAIR CORA-BRAMBLE: Okay. I

think that was a point well taken in terms of the access part of the IOM definition.

Nicole, next steps?

MS. MCELVEEN: Yes.

CO-CHAIR CORA-BRAMBLE: She didn't think we could do it, by the way. Let the record show.

MS. MCELVEEN: I had confidence. I thought we would go until 2:00. I thought we would go until 2:00, though, but it's 12:05, so kudos to the group and our Co-Chair here.

Yes, so we are on next steps. So there are several documents, as you can imagine, that we are going to pass by the Committee, so I wanted to first review that, and these specific pieces we will be circulating to you in the very near future.

First is the summary of the meeting, so minutes from our meeting here. The NQF staff will produce a document that describes the protocol that the Committee has

suggested we use for reviewing the 700-plus measures in our current portfolio.

We will also provide a document that has some conclusions and recommendations around the methodological issues. There were several recommendations the Committee made around that, suggestions around changing terms and some word smithing, so that will be a document we will send you.

The draft Call for Measures, you will receive that, as well as our approach for how we're handling disparities moving forward. There is some thinking that we have to do on our side in terms of the changes that we'll be able to make to the form for our current Call for Measures that will happen pretty soon, versus changes that may be a little bit longer term moving forward. So we will discuss that a little bit internally but certainly bring that back to the group for review.

So, just to recap for the time line purposes, the next time we meet in person

as a group will be when we review measures for consideration. Between now and that time, there will be a few conference calls that will obviously take place. We certainly want to get your review on several of these documents, and we'll assess if it's needed, maybe, to have a conference call to discuss any topics in particular.

One thing that did come out that might be helpful for the group is including a very brief webinar, maybe 30 minutes to an hour, around the work that's happening with MAP and the National Priorities Partnership, and MAP is the Measure Applications Partnership.

I know there's definitely a lot of crossover between their work and what we're doing here, so I thought maybe a short webinar to capture where those goals and efforts align and overlap might be helpful as a contextual information for the group.

I will, obviously, be in contact,

as well as the other staff will be in contact with the group for setting up the additional conference calls that may follow. Anything else?

Oh, and with reviewing the documents, I did want to mention that I know you guys are very busy, but I just wanted to emphasize the importance of reviewing these documents. All of our materials and our work is public.

So we definitely want to make sure that we are really capturing the Committee's intent, what you have mentioned, so it is important that you review these documents and really make sure that we're on the right path, because it will be public, and we will get comments, good and bad comment, but, you know, I just want to emphasize that to the group.

Finally, I want to thank our Co-Chairs, Denice and Dennis, who have steered us on the past few days to accomplish our goals and to end early, which is always a plus, so

thank you to the Co-Chairs, and if there are any additional questions -- sure.

DR. JACOBS: I just have one last question. I'm curious as to who submits these measures. Who does it, and what are their motivations? I'm just curious.

DR. BURSTIN: It's pretty complicated. We're masochists. It's a very complicated process. We tend to -- there are a large set of large measure developers, the Joint Commissions, NCQAs of the world, CMSs, contractors, but then you'd be surprised.

There's a lot of leading health systems, for example, Minnesota Community Measurement, Health Partners. Partners increasingly in Boston are submitting measures, so that's why I think we don't realizes you may have measures that you've been using in your internal systems, which is actually some pretty good data that oftentimes those are great ones to submit.

They don't have to come out of the

AHRQ. Sorry, didn't mean to leave off ARHQ, of course not. You know, again, the points both Luther and Norman raised about specialty societies are also very involved in submitting measures to us.

DR. JACOBS: Can we propose measures as members of the Committee?

DR. BURSTIN: You can. You'd have to recuse yourself from that review, obviously, but, yes, you can.

MS. MCELVEEN: No, but that also brings up an important point that if you are aware of measures that are out there or developers who are working on measures, certainly mention to them, obviously, this work, or feel free to provide us with that information so that we can follow up accordingly.

Yes?

DR. MARYLAND: And I believe you've had many requests for contact information, so that will be coming?

MS. MCELVEEN: Yes, thank you for reminding me. There was a request made to circulate contact information to the group, so if folks are comfortable with that, we can circulate that information. Okay.

CO-CHAIR CORA-BRAMBLE: And I really would like to see the work that you talked about earlier about the --

DR. JACOBS: I sent it to you, the language barriers. Yes, Carliner, did you get it? I don't think it went to the whole Committee for some reason.

CO-CHAIR CORA-BRAMBLE: Okay. All right.

DR. JACOBS: So you did get it?

CO-CHAIR CORA-BRAMBLE: If somebody could forward it to me, that would be great.

DR. JACOBS: Okay.

CO-CHAIR CORA-BRAMBLE: Thank you.

MS. MCELVEEN: You do have -- the travel expense form I think was recirculated

to the group, so you have that, and, finally, lunch is available out in the hall, so feel free to grab and go or stay and chat.

CO-CHAIR CORA-BRAMBLE: Okay, thanks to all.

MS. MCELVEEN: Thank you, guys.

CO-CHAIR CORA-BRAMBLE: Thank you very much.

(Whereupon, the foregoing matter was adjourned at 12:10 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Healthcare Disparities

Before: NQF

Date: 07-12-11

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Court Reporter