Risk Adjustment & Socioeconomic Status Expert Panel Orientation Call
December 9, 2013, 1:00-3:00pm ET

Purpose:

- orient the Expert Panel to NQF and the project;
- begin discussion of key questions; and
- plan for the January in-person meeting.

Attendance

NQF staff: Karen Pace, Suzanne Theberge, Taroon Amin, Karen Johnson
Panel members: Kevin Fiscella (co-chair), David Nerenz (co-chair), Jean Accius, Alyce Adams, Mary Barger, Susannah Bernheim, Monica Bharel, Mary Beth Callahan, Larry Casalino, Alyna Chien, Marshall Chin, Nancy Garrett, Atul Grover, David Hopkins, Dionne Jimenez, Steven Lipstein, Eugene Nuccio, Sean O'Brien, Pam Owens, Ninez Ponce, Thu Quach, Tia Sawhney, Nancy Sugg, Rachel Werner
Other attendees: Krishna Aravamudhan, Jeff Burton, Corette Byrd, Laurie Coots, Tom Croghan, Lindsay Erickson, Jim Feldman, Robert Fornango, Bruce Hall, Karen Heller, Shawn-Marie Herring, Johnny Hood, Dena Jaffe, Gary Kitching, Lindsey Lesher, Leslie Magness, Diane Maiwald, Pamela McMaster, Kathryn Meehan, Ann Page, Koryn Rubin, Rafael Ruiz, Ellen Schneiter, John Shaw, Joe Stephansky, Chris van Reenen, Maggie Windle, Melinda Whitbeck

Call Summary

Orientation & Introductions

- The expert panel members introduced themselves and noted why they were nominated for this panel.
- NQF staff provided a brief introduction to NQF and to the project's timeline, approach, and goals.

The discussion was based on the briefing memo sent to the Expert Panel in advance of the call and posted on the project web page. The Expert Panel was asked to identify additional topics or key questions that should be included in the Panel's deliberations. Following is a summary of the discussion points.

Scope

- In response to questions, staff clarified that the project is not limited to SES and could consider other social or demographic factors such as literacy, English proficiency) and can include pediatric populations.
- Suggested modifying title beyond SES
- Although some of the same issues apply to adjusting for upfront payment for services (e.g., capitation), that is not included in this project—this project is focused on performance measures.

Definitions

- Patient-reported outcomes in the domain of experience with care can include patient activation and engagement

- For healthcare disparity, the NQF definition will be used: differences in health care quality, access, and outcomes adversely affecting members of racial and ethnic minority groups and socially disadvantaged populations

Background

- Specific expressions of divergent points of view on the topic would be helpful.
- Stratification is also a method of adjusting and could have the same implication that it's ok that quality of care is different for different populations.
- Request to also look at some concrete examples of measures (case studies) that were submitted to NQF that use risk
    - Often very little information is given about intent to use or use of information collected from measures, and more concreteness about intended use of measures when submitted would be helpful in general.

Assumptions, Values, Core Principles

- There was general agreement with the core principles. Some suggestions were made.
- Community sociodemographic factors may influence individual outcomes – individuals in high poverty areas are at higher risk regardless of personal risk factors – neighborhood may be more predictive than individual income. This should be included in the first core principle.
- Measurement should not increase disparities.
- The concept of "fair comparison" (second core principle) is too ambiguous and should be replaced with correct inferences.
- Potential fourth principle: Risk adjustment may be constrained by data limitations and collection burden.

Outcome Performance Measures

- Patient engagement/empowerment would be considered under patient-reported outcomes
- Community level factors need to be included
- Does figure 2 work for organizations, or only for individuals? What about organizations that have fewer resources to improve care because their population is low SES?
- How we resource safety nets is different in every city – some cities may have more resources than rural safety net facilities, for example
- Safety net providers have greater needs and it costs more to provide care to their patients, but they have more limited resources: intersection between resources at the system level and health care needs at the population level.
- Interactional effects of substance use and dual diagnosis with SES on outcomes. Substance use would be considered a clinical factor. Also need to think about ability/difficulty of data collection.
- Thinking about different factors but what are interventions that can improve outcomes in the long run?

Use of Outcome Performance Measures in Accountability Applications

- A single standard of what should be done may not be appropriate for all uses. Perhaps think of scenarios where risk adjustment should and should not be used?
- Heightened concern when thinking about payment rewards and penalties.

- As a provider, I'm interested in seeing what's different so that I can see what I can do differently, but use for payment is worrying.
- NQF endorsement pertains to the specified, risk-adjusted outcome performance measure. Currently, endorsement does not extend to implementation processes. However, it is possible that the recommendations from this project may apply to use of the measure (e.g., creating comparison groups for purposes of pay-for-performance).
- NQF criteria address reliability, validity, and risk adjustment so if the outcome performance measure is a reliable and valid indicator of quality, it should be suitable for use in accountability applications. If there should be different standards for reliability, validity, and risk adjustment for different accountability uses (e.g., public reporting, pay-for-performance), those will need to be identified with clear rationales.

Methodological Considerations

- What is the cost in technology and data gathering on community clinics – are we asking too many questions – what is the cost to clinics?
- How one might apply risk adjustment to provider up or down relative to a setting: how final model is applied to risk adjust for performance
- How to look at interventions outside of provider-patient interactions – state and community resources or education or interventions
- Risk adjustment includes stratification

Public Comment

- Not a binary issue – perhaps panel could present issues and recommendations in a way that recognizes that: there's risk adjustment, there's partial risk adjustment, there's gradations and it's not for every variable
- There isn't an NQF endorsed way to measure SES or social disadvantage – does there need to be? Is it feasible?