**NATIONAL QUALITY FORUM**

**Moderator: Sheila Crawford**
**December 9, 2013**
**1:00 p.m. ET**

Operator: Welcome to the conference. Please note that today's call is being recorded. Please standby.

Karen Pace: OK. Suzanne, are you still there?

Suzanne Theberge: Yes, I am still there.

Karen Pace: And I believe other people are on the line.

Suzanne Theberge: Do we have folks on the line yet?

Female: Hello.

Operator: Yes, ma'am.

(Off-mike)

Suzanne Theberge: I'm sorry. We can't hear you.

(Off-mike)

Karen Pace: OK. Suzanne, should – we should probably go ahead and start the streaming so that if people are just listening on their computer, they can kind of know where we're at. Is that correct?

Suzanne Theberge: Go ahead and start streaming.

Karen Pace: OK.

(Off-mike)

Karen Pace: Hello, David can you hear us?

Ellen Schneider: Am I good?

Karen Pace: Who is that?

Ellen Schneider: This is Ellen Schneider.

Karen Pace: Hi, Ellen. We can hear you. Yes, we're' just doing a test here while people are gathering just want to …

Ellen Schneider: OK. I'm going to put myself on mute.

Karen Pace: OK.

Suzanne Theberge: This is Suzanne, NQF. Are – is anybody having trouble seeing the webinar? You should be seeing an opening slide right about now.

Male: Yes, I have it.

Suzanne Theberge: OK. And do we have any panel members on the line yet?

Female: There is no problem with patching him in. Is there?

Suzanne Theberge: I'm sorry. Patching in who?

Female: Hi, I'm calling on behalf of Norbert Goldfield. I have to call – I have to try to conference him and he is in Italy right now.

Suzanne Theberge: OK.

Female: And there is no problem with me trying this I assumed.

Suzanne Theberge: Not that I'm aware of now. Thank you.

Female: OK. I'm going to try it right now.

Suzanne Theberge: OK. Great. Thank you.

Female: OK.

Female: Oh, my gosh. There is the problem.

Female: We're going to have to tell her if she can …

Suzanne Theberge: (Amy)?

Operator: Yes, ma'am.

Suzanne Theberge: Thank you. Can you temporarily mute that line just well the whole is on.

Operator: Yes, ma'am. I did.

Suzanne Theberge: Fantastic. Thank you.

Operator: You're welcome.

Steven Lipstein: Suzanne?

Suzanne Theberge: Yes.

Steven Lipstein: Hi. This is Steve Lipstein. I'm on the Outlook Web App and I'm trying to figure out what my username and password is.

Suzanne Theberge: OK. You're not the only person having that trouble. I just got an e-mail about it as well. You should not need to have a username and password getting in – to get into the webinar. Hang on one moment, I'm going to …

Karen Pace: Right. So, there's – let's make a distinction here. You do need a username and password for SharePoint but the webinar information – we should just be able to click on the URL and it will ask you for some information but there is no – there is a confirmation code. All of that is in the agenda and the materials, the briefing memo we sent you.

Steven Lipstein: All right. All right. So, did click on URL because we have a SharePoint with this.

Female: Yes. You should need it for this. We went into the e-mail. Just click on the URL. It brought up this page asking us for a username and a password on Outlook Web App.

Suzanne Theberge: OK. I know the issue. Let me – OK. Yes, we actually just got an e-mail from one of the other committee members. Copy and paste instead of clicking the link. It will work.

Female: OK.

Suzanne Theberge: So, instead of click – sorry about that.

Female: It's OK.

Male: I'm sorry. I didn't hear the solution there. What was the solution to the logging in on that?

Suzanne Theberge: Just copy and paste the link rather than clicking on it. For some reason, there's a glitch when you click on the link. It asked for the e-mail inserted some kind of request for password. If you just copy paste, it should work.

Male: So, you get to NQF site and this is display name, e-mail address.

Karen Pace: Yes. That's to sign on into the webinar.

Male: It works.

Suzanne Theberge: Super. So, we're just at 1 o'clock now. Can we – can any – can panel members that are on the phone introduce themselves so we can see how (we) things started.

Karen Pace: Suzanne, why don't we do – we'll do roll call when we get to Expert Panel introductions?

Suzanne Theberge: OK.

Karen Pace: Let's give it just a minute but let's just double check. Is Kevin and David on? If you would just let us know, you're on …

Kevin Fiscella: Yes. Kevin is here.

David Nerenz: Yes. Dave is here, too.

Karen Pace: OK. Great. So, wait …

All right. I think we'll go ahead and get started. We'll get started on the call. Operator, are there other people still in the queue to get call entered into the call or we pretty well set.

Operator: Yes, ma'am. We just have a few right now in the main conference. We have 20 participants. We'll open the line.

Karen Pace: OK. All right. Thank you. And if we – you'll monitor the line if we get any interference so you can – you can mute those lines, is that correct? I'm hearing some feedback when I talk.

Nancy Sugg: Hi. This is Nancy Sugg. I've just joined the call.

Karen Pace: OK. Thank you. All right. So, I need just do a quick sound check. Can everyone hear my voice? This is Karen Pace.

Male: You're good.

Female: Yes.

Male: Yes.

Male: Yes.

Karen Pace: OK. Excellent. So, Suzanne, you want – let's go ahead and get started and then we will quickly get to the Expert Panel introduction.

Suzanne Theberge: Great. Good afternoon, everyone. This is Suzanne Theberge. I'm the project manager for this Risk Adjustment and Socioeconomic Status Project at NQF. Before we get started, I want to go over a couple of brief housekeeping

items. We'd like to ask you to put your line on mute if you're not speaking to reduce interference, and if you are dialed in, please turn off the sound on your speakers. We're also streaming audio and that causes a lot of interference as we've already heard.

The other thing we'd like to ask is that you not put us on hold during this call because we'll – we will all hear your hold music. If you have technical issues, you can send us a chat message in the lower left-hand corner. There's a chat box and we are going to be going through some slides and doing some screen sharing today. Once we get into that, you'll have the options to – at the top of the screen that enlarged and that might help you read some things more clearly.

So, with that, I'm going to turn this over to Karen to go over our agenda.

Karen Pace: Welcome, everyone. Thank you for joining us and we are really looking forward to this introductory call. So, very quickly, we will get into introduction. Suzanne will lead us through a brief introduction to NQF and the project overview and then we'll come back to the specific project goals and approach and really start getting into a discussion of topics and key questions so that we make sure that we have everything on the table that we need to get into during our in-person meeting in order to move to recommendation.

And as with all of NQF calls and meetings, these are open. It's primarily for the Expert Panel discussion but we will have a period of time towards the end of the call for others who have dialed in if they want to make any comments or questions and then we'll quickly review next steps and adjourn and I'm sure our time will fly by today.

And the main things that we want to get out the call is certainly to orient the panel to NQF and the project and as I said, begin discussion of the key questions and make sure that we have things on the table that we need to be sure to address at our January in-person meeting and our co-chairs, Kevin and David will help us through some of those discussions.

So, right now, I am going to turn it over to Kevin and David to start us out on Expert Panel introductions and we would like you to give us your name and position and your organization and maybe just a sentence or two about what led to your nomination for this Expert Panel for this project.

So, I'll turn it over to Kevin first.

Kevin Fiscella: Good afternoon. I'm Kevin Fiscella. I'm a professor of Family Medicine at University of Rochester. I have a longstanding interest in health care disparities and implications for (advising them). I agreed to do this because this is – consider this to be your – a really critical questions and one that I hope that the entire group can eventually come to consensus once we heard from everybody on a way to move forward.

Karen Pace: OK. David?

David Nerenz: Hi. Dave Nerenz is here. I'm the director of the Center for Health Policy and Health Services Research at Henry Ford Health System in Detroit. I feel like I'm bit in the middle of some of the crosscutting points of view and issues in front of us here. (That was) 20 years or so, I've worked on a number of projects having to do with reducing or eliminating racial and ethnic disparities in health care. So, I'm concerned about that.

For a long time, I've just been interested in measurement in general and some of the technical details of how it gets done, but I have a concern about the stability of safety net providers. So, all those things come together I think in our (charge).

Karen Pace: OK. And what we'd like to do, we have list of Expert Panel members on (inaudible) free to go through in alphabetical order. So, I'll see first Ms. Jean and I'm not, you know, tell us how to state your last name.

Jean Accius: Sure. It's Accius.

Karen Pace: Accius. OK, great.

Jean Accius: Well, good afternoon, everyone. My name is Jean Accius. I'm the director of Health and Long-Term Services and Supports within the Policy Group at AARP. This is an area that is place of interest for myself, as well as for our organization particularly looking at how disparities accumulates over the course of the lifetime. So, looking at really the lifespan perspective as a (cumulative) disadvantage and how can we design system both in terms of health and the delivery system kind of its long-term service and support thoroughly addressing issues in a meaningful way.

Karen Pace: OK Alyce?

Alyce Adams: Hi. This is Alyce Adams. I'm a research scientist and chief at Health Care Delivery and Policy at the Kaiser Permanente Division of Research here in Oakland, California. My own researches are health services and policy research or studying disparities and it was recommended by (Dr. Dave Baxter) who the lead (inaudible). I'm sorry?

Karen Pace: I think just a reminder for people to keep their phone on mute when they're not talking I think that was a little bit of interference there but thank you Alyce.

Mary Barger?

Mary Barger: I'm Mary Barger. I'm with American College of Nurse Midwives. I am a nurse-midwife and perinatal epidemiologist. So, I've had a long-term interest in health disparities, having taught in a school of public health for a period of 20 years and look at health disparities in my research-related perinatal health outcome.

Karen Pace: OK. Susannah?

Susannah Bernheim. Hi. This is Susannah Bernheim. I'm a family physician and I'm currently the director of the Question Measurement Group at Yale University of Center for Outcomes Research and Evaluation and we've developed a number of CMS' outcomes measured. So, we've done a lot of thinking about these issues in the course of development. I'm a also a physician caring for patients at a (certainly) qualified Community Health

Centers. So, I deal with those issues in my practice as well and have some history of doing research in the intersection of (health) quality and socioeconomic disparity.

Karen Pace: OK. Thank you.

Monica?

Monica Bharel: Good afternoon, everyone. This is Monica Bharel here. I'm the chief medical officer of Boston Health Care for the Homeless Program also a practicing internist associated with Harvard School of Medicine and BU School of Medicine. In my work with Health Care for the Homeless, I've been looking at risk adjustment for homeless individuals and have firsthand experience with socioeconomic disparities and patient population. Thank you.

Karen Pace: OK. Mary Beth?

Mary Beth Callahan: I'm Mary Beth Callahan. I'm a senior social worker at Dallas Transplant Institute and I've worked with nephrology patients for 30 years in dialysis and transplant settings and have worked with Council of Nephrology Social Workers developing outcomes training program.

Karen Pace: OK. Lawrence?

Lawrence Casalino: Hi. This is Larry Casalino. I'm a professor at Weill Cornell Medical College where I'm chief of the Division of Outcomes and Effectiveness Research actually soon to be chief of Division of Policy and Economics. I was also a family physician in full time private practice for 20 years in Half Moon, California.

Karen Pace: Thank you. Alyna?

Alyna Chien: Hi. My name is Alyna Chien and I'm a general pediatrician and health services researcher based at Boston Children's Hospital and Harvard Medical School. I work on how we intensify physicians and trained by both Larry and Marshall and I'm looking also at how the incentives received – we received might influence disparities. Right now, I have a grant from NICHD to look at

geographically-based information and how that may or may not help us that are matched resources to the more complicated patient with the simple ones.

Karen Pace: OK. Thank you. Marshall?

Marshall Chin: I'm Marshall Chin. I'm a general internist in Health Service Research with the University of Chicago, and I do a lot of work including client care in the safety net. I'm also a disparities representative on another (inaudible) committee. This is a Measure Application Partnership Coordinating Committee and this issue comes up all the time. We talked about disparities and so it's (quite) they were having this committee devoted to trying to (inaudible) to division about the (technical difficulty).

Karen Pace: Thank you. And Norbert, did you get connected in?

Norbert Goldfield: Yes. Can you hear me OK?

Karen Pace: Yes.

Norbert Goldfield: This is Norbert Goldfield. (Inaudible) perhaps that are rolled in medical director of the research group at 3M Health Information Systems and over half of the Medicaid Programs uses the ERG-like tools that we've developed for each of the health care conference for more than – more than 20 percent of Medicaid Programs in the country in addition to work with MedPAC and CMS on the (the provided) issues. In addition, I'm an internist for Health Center where we had a cascaded contract (inaudible) into eligibles and lastly as an example (inaudible) perspective on the board of health care for all – which we affectionately say first in the family care.

Karen Pace: OK. Thank you. Nancy?

Nancy Garrett: Hi. Can you hear me?

Karen Pace: Yes.

Nancy Garrett: Oh, great. So, I'm the chief analytics officer at Hennepin County Medical Center. I do analytics and I.T. and I'm trained as a sociologist and demographer. So, I'm very interested professionally in type of social factors

on health and I'm also on NQF Cost and Resource Use Steering Committee. And again, this issue comes up all the time. So, I'm really excited that we're going to be addressing it, and as a safety n et care provider, we're nearly concerned about this issue (increasingly) our reimbursement and ability to do well. It's really tied to how we perform on Cost and Quality Measures for very complex population. So, we have a really strong in this.

Karen Pace: Thank you. Atul?

Atul Grover: Yes. Hi. This is Atul Grover. I'm responsible for policy and strategy at the Association of Medical Colleges. I'm a general internist in the Health Services Research by background and most of the people that have introduced themselves on this call are actually one of our member institutions or teaching hospitals or medical schools and we do about 20 percent of all the clinical care in the country even though we're 6 percent of hospitals, about 40 percent of all of the charity in-patient care.

And our populations as you just heard about our large highly complex and often very vulnerable from a variety of perspectives and so as – which (inaudible) go join the readmission discussion, we began to think deep into the data around this potential risk adjustments and are very interested as a collected group of caregivers with an academic medicine in the outcomes.

Karen Pace: OK. Thank you. David? Is David Hopkins' on?

Female: He's on? He's not?

Karen Pace: OK.

Female: He's not.

Karen Pace: All right. Let's go on to Dionne.

Dionne Jimenez: Hello. This is Dionne Jimenez and I am a health policy and research coordinator for this Service Employees International Union and my work for the International but I'm actually based in Los Angeles California, and I've been working – most of my works have been focusing on quality and

reimbursement issue affecting our represented members which vary from, you know, actual resident doctors down to the support staff and hospitals, clinics, nursing facilities and home care, as well as we will present workers in other industries.

But I've particularly been interested in the hospital value-based purchasing programs and the skilled nursing facility pay-for-performance programs, and as an organization. So, this was very important to us looking at health disparities, as well – as well as looking at some risk adjustment and its impact on safety net providers.

Karen Pace: OK. Thank you. Steven?

Steven Lipstein: Hi. My name is Steve Lipstein. I am the president and chief executive of BJC Healthcare in St. Louis where relatively large health care delivery organization, the largest provider of services to the uninsured and Medicaid populations in Eastern Missouri and Southern Illinois. I also serve as the vice chairman of the board of governors at the Patient-Centered Outcomes Research Institute a section that we referred to as PCORI.

And I think, I was encouraged to serve on this panel because I've been outspoken about the absence of risk adjustment for people who live with difficult life circumstances and the unintended consequence to that absence of risk adjustment has caused providers to avoid geography that is characterized by people with difficult life circumstances which actually exacerbates disparities in access to health care for vulnerable populations. So, I come to this thinking that topic before us is critical and essential if we're going to reduce disparities in access.

Thank you.

Karen Pace: OK. Eugene?

Eugene Nuccio: Hi. Eugene Nuccio from University of Colorado Anschutz Medical Center. I've been for the last decade worked on developing risk adjustment prediction models to risk adjust home health outcomes nationally. I did some experimental work with – under the sponsorship of MedPAC to look at how

you might use provider characteristics relative to the geography that they serve to utilize STS variables in this prediction models.

So, I'm very much looking forward to discussing these topics with everyone.

Karen Pace: OK. Sean?

Sean O'Brien: Hi, everyone. I'm Sean O'Brien. I'm a biostatistician at Duke University Medical Center and work with several large National Cardiovascular Registries and one of the things we do with the data involves developing risk prediction models and performance measures. So, one of my interests involves developing really assessing performance and validity and reliability of performance measures and I've been involved in a couple of other NQF activities including the measure testing task force a couple of years ago and more recent steering committee for health care disparities and cultural competency.

I currently serve on AHA, ATC Measure Testing task force and I think that they were the source of my nomination to this task force.

Karen Pace: Thank you. Pam Owens?

Pam Owens: Hi. I'm (inaudible) with the analysis on health policy researcher. I have been at the Agency for Healthcare Research and Quality for the past 12 years and (some in) capacity and the real reason I'm on this particular panel is because I am a scientific lead of the AHRQ Quality Indicator. It is something that our (cost) been grappling with, and I'm sure in the federal policy context, we've been grappling with this.

So, I very much look forward to your insights, as well as provide you a little bit of a different perspective. Thank you.

Karen Pace: OK. Ninez?

Ninez Ponce: Hi. It's Ninez Ponce from UCLA. I'm a professor at the School of Public Health and senior research scientist at the UCLA Center for Health Policy Research which houses the California Health California Health Interview

Survey where I'm a the P.I. I'm very interested in – I'm health economist interested in getting the incentives right to make sure that providers see patients that have complexities beyond clinical factors.

I'm here because I've been working with DSC Community Health Centers from AAPCHO, Association of Asian Pacific Community Health Organizations and actually two who's going to be next on the line with Asian Health Services in relates thinking through including especially (in terms) of health and risk adjustment model.

Karen Pace: OK. And Thu?

Thu Quach: Hi. This is Thu Quach from Asian Health Services. We're a Community Health Center in Oakland Chinatown and we're –I believe I'm on this because we have a exploratory project funded by the California Endowment where we're trying to look at our data and including limited English proficiency and poverty indicators in a risk adjustment. We've also been convening meetings with academic partners like (mini) expose, as well as with the other AAPCHO Health Centers to look at their data for modeling.

Karen Pace: Thank you. And Tia?

Tia Goss Sawhney: Hi. I'm Tia Sawhney. I'm the director of Data Analytics and research with the Illinois Medicaid plans. Risk adjustment is obviously important to us. It's – there have been a professional interest out of the work for the past five years and I'm a qualified health insurance actuary. I serve on Society of Actuary and Academy of Actuary Committees on the topic in work groups in risk adjustment in socioeconomic – and socioeconomic risk status within risk adjustment with the topic of my doctor (inaudible) – dissertation topic health dissertation.

Karen Pace: OK. Thank you. Nancy?

Nancy Sugg: Hi. This is Nancy Sugg. I'm an associate professor of Medicine at the University of Washington in Seattle and I, on several levels, I'm interested on this topic. I'm a primary care internist and I worked in a clinic that is predominantly homeless and low income with high levels of mental health

and substance abuse and I am on the receiving end of the paper performance. So, I look at it from that angle. I'm also the medical director for Harborview Medical Center's homeless downtown programs and I need to have ability to look at my providers to see who is under serving and who may be superiorly providing care.

And then I do program development for Seattle and I look at the types of outcomes that I'm being held accountable to an evaluations. So, for all those reasons, I'm very interested in this topic.

Karen Pace: OK. Thank you. And last but not the least, Rachel?

Rachel Werner: Hi. I'm a – I'm a professor at the University of Pennsylvania where I am a general internist and a health economist. I do research in the area of the use of financial incentives to improve health care quality and have done work looking at those incentives affect disparities in care.

Karen Pace: OK. Thank you. Well, thanks you all for joining us and getting us through that introduction, let me just circle back to one, is David Hopkins on the line?

OK. So, I'll turn it back over to Suzanne who's going to take us through just a brief introduction to NQF and the project overview.

Suzanne Theberge: All right. Thank you, Karen. So, we just wanted to spend a couple of minutes giving a brief intro to the National Quality Forum for those of you who are new to our work or hasn't bee on one of our panels before. NQF was created in 1999 in response to the recommendations from the President's Advisory Commission on Consumer Protection and Quality in Health Care Industry. We are nonprofit voluntary consensus standards setting organization. We're also a membership organization. We have over 400 members and they are organized into eight stakeholder councils. Our board of directors are – is also multi-stakeholder.

We have a three-part mission to improve the quality of American health care by building consensus on national priorities and goals for performance improvement, by endorsing national consensus standards for measuring and

publicly reporting on performance and promoting the attainment of national goals through education and outreach programs.

Karen is going to go over this in more detail soon but this – this – to touch on this briefly, the purpose of this project is two major purposes. First, to identify and examine the issues related to risk adjusting outcome and resources performance measures for SES or other socio-demographic factors. And second, to make recommendations regarding if when and how outcome and resource use performance measures should be adjusted for SES or other socio – socio-demographic factors. As part of the second purpose, we'd also like the panel to make recommendations for NQF's endorsement criteria for outcome and research use performance measures.

Now, I would speak a bit about the logistics of the project. This is the orientation call. Our next step will be to meet in person in January at NQF office in DC and then following that meeting, that two-day meeting, we'll have two follow-up calls to continue the discussion and to review the progress of the draft report that NQF staff will write up after the meeting. These calls are scheduled for February 10th and February 18th. Once we have a draft report, that will go out for public comment. We're anticipating that one in February 24th and March 25th and during this time, the public is invited to make comments on – on your recommendations.

Following the comment period, the panel will reconvene on April 9th to discuss the comments received and make changes afterwards. Once the committee has finalized their recommendations, the report will go to NQF's Consensus Standards Approval Committee, the CSAC in May and then to the NQF Board of Directors in June for their discussion and review and approval. We anticipate the final report and final recommendations will be completed by the end of June.

So you – I think we may have mentioned this in some of the materials that we sent out earlier but to go over this again, you've been selected as an individual based on your expertise to sit on this panel. I mean you're not – you're not seated as a representative of your organization. We asked – we – we see the multi-stakeholder panel to serve as a copy for our multi-stakeholder

organization but again we asked that you expressed your own views during our discussion.

In terms of specific responsibilities for the panel members, we asked that you identify and disclosed all your potential biases and we will go over that at the in-person meeting in January. We asked that you returned all calls and meetings and that during these calls and meetings, you participate in the discussion and in the involvement of the recommendation. We also asked that you review drafts of meeting summaries and reports for completeness and correctness, and then that you review the public comments and help draft the responses to those.

So, here's the contact information for the staff, for the projects as well as the SharePoint page that we'll be using to share all materials for the panels going forward. We'll just post everything there, so that you can download it. We find that sometimes e-mail attachments get lost. So, now I'm going to turn this over to Karen to speak further about the goals and approaches for the project.

Karen Pace: OK, I'm going to screen share now with the memo that we sent to everyone. We'll be using that as a basis for the rest of our conversation. So, let me just rip that up here. OK, so those of you on the webinar should be able to see the briefing memo and I'm looking at – looking at the page that begins with project on risk adjustment in SES and the purpose and approach.

And – and we've been talking about the purpose of this project is really to identify and examine the issues related to risk adjusting outcome and resource use performance measures for socio-economic status or other socio-demographic factors such as race and ethnicity. And then to really make specific recommendations regarding if, when, and how outcome and resource use performance measures should be adjusted for those factors.

This also relates to obviously NQF's endorsements and measure evaluation criteria, so we'll be, you know, as needed, making recommendations regarding any adjustments to our current criteria and evaluation approach. So as with all of our projects, a central part of our approach is really to convene a

multi-stakeholder expert panel and as Suzanne has already mentioned, you know, all of you are seated as individuals based on your experience and perspective, and we really tried to get a – a variety of experience and perspectives on our – our panels.

And we will be, you know, doing the bulk of our work during the in-person meeting. It's two days as Suzanne mentioned, January 15th and 16th and one of the things that we'll be doing during this meeting that may be a little bit different than some of our other projects though we've done this in some is to have some panel presentations involving some of you. And so – was one of things we asked in the beginning of the briefing memo is to kind sink in your mind as – as you are reviewing the topics and key questions if you have particular analysis or perspective that might focus in on any those of key questions, to keep that in mind because we'll be working with our co-chairs Kevin and David after this call to really and more thoroughly planned that in-person meeting and what kinds of panel presentations might be useful as really a foundation or grounding for our expert panel discussions.

And we'll follow up after this call with an e-mail with more specifics about that but basically at that meeting, we'll be doing a lot of the discussion and drafting those initial recommendations. We see – think that we'll need some follow-up discussions and that's why we already have those two follow-up calls schedule that Suzanne mentioned in our timeline. So, I am going to now asked Kevin and David to help us go through this memo and some of the key topics and issue – key questions that we've already identified but what – what we would really like to do today is make sure that we identify if there are other issues or key questions that we need to consider in the mix of our work, so that we get those on the table and think about how we bring that into our discussion at the in-person meeting, or if there's anything in the memo, the background materials and key questions that you think really is off the table. We'll welcome those kinds of comments as well.

The other thing that we are interested in is if you have any specific additional references or materials that you think is really key for informing the panel and informing our discussions as we go forward, we're also interested in obtaining those and if probably again will be best to have you respond to a follow-up e-

mail with those specific, so that we can actually spend our time today talking about more substantive things. So, I'm going to stop there and maybe before we get into discussing those, I'm going to just – because we're doing pretty good on time is just stop and see if anyone has any specific questions about the project goal, the way we're going to get the work done, etc, maybe we'll take those questions now before we get into more of the discussion.

Nancy Garrett: Yes, this is Nancy Garrett from Hennepin County Medical Center. I have a general question about the title of the projects. So, Risk Adjustment/SES but when I read them out, it seems that we're all focusing on socio-demographic factors in general and perhaps even we may be focusing on disadvantage populations and so that – I think the title is important in terms of describing the work. So, may be you could comment a bit about that?

Karen Pace: Sure and that's a good observation and we – we definitely can use some more broad term. I think that the genesis of that is through the initial discussions, kind of the hot button issue that's been coming up and some of the, you know, contract work and contract proposals and things, so I think that's a good observation and, you know, we can certainly expand that terminology, so that it doesn't look quite it's that narrow.

Nancy Garrett: OK, thank you.

Susannah Bernheim: This is Susannah Bernheim, just one quick question on references. We and I imagine others in this group have work that is not yet in the PeerView Press but might be relevant to share if it could be done confidentially. Do you want us to indicate that as well? And so we think about a way to share some analytic findings that aren't yet public.

Karen Pace: Yes. I think that would be very useful and yes please, please let us know about that and that may be also something to think about if you think it would be useful to share at our in-person meeting or you know what specific question that might addressed.

Susannah Bernheim: OK.

Karen Pace: Other questions? All right, well I'm going to first ask Kevin and David to make any opening remarks and then if it's OK with them we can kind of work through the memo and see if people have any comments or issues, or key questions to talk about or to address and so first is Kevin to start, then David.

Kevin Fiscella: Just saying I'm – I'm very excited to be able to collaborate with such an expert panel, we – we have a very wide range of – of expertise on the panel and, you know, I'm optimistic that we can come to a foothold of conclusion at the end.

David Nerenz: Yes and Dave here. First of all I'd like to thank Karen and Suzanne for what I think a remarkably good kickoff of body of material for us to look at. I think many of us who has been together or in separate instances on things like Institute of Medicine Committees or other similar work groups have found that it's very important at the beginning to make sure that we're all on the same page in terms of – of the charge, what the end product of the work is supposed to look like what's in scope, what's out of scope and I think we have a pretty good framing of that already in front of us. I will say, though, went through the materials, so I had a specific question on the issue of literacy and then I'll extend that now to – of – of variable like limited English proficiency.

My own preference is that those being included in our discussion but I did wonder, given the definition of the scope of what we're talking about since those are not strictly economic variables, whether they are in. So, I might sort of post that as a question to Karen and Suzanne and they can probably bounce it back to the group. Our – our things are submitted in sort of – I'll call it the language domain, literacy English proficiency. Are those within our chart?

Karen Pace: This is Karen. I think we can certainly consider them and I think that, you know, it's kind one of these definitional things of how broad we can talk about these things, you know, and I think initially we would definitely want to consider that or see how that plays out. You know, as with all of these once we go through the conceptual piece, then we get down to practicalities in terms of, you know, how – what day it exist and how we can actually use these kinds of concepts but I think at this point I would say that it's in for discussion.

David Nerenz: Yes and also –

Tia Sawhney: I mean – I think that we most literally, I mean it is socio-economic status and obviously ability to communicate is very socio.

Karen Pace: And – and who is that, I know this is a – a little difficult to do these discussions on the phone with just voices and not faces but if –

Tia Sawhney: Yes, my apologies. This is – this is Tia Sawhney.

Karen Pace: OK.

Tia Sawhney: So, I mean I would – even though I – even though I obsessed on dollars, I found the question a little odd in – in that, you know. There's more to socio-economic status than just money though.

Alyna Chien: Hi, this Alyna Chien from Boston Children's Hospital. I had a similar scope questions about the pediatric age range. It was the idea going to be – to treat age as a demographic variable because there certainly are these very issues at both ends of the age spectrum, so or to consider all these issues as being similar in both pediatrics and adult and that we're going to do a pediatric version and an adult version.

Karen Pace: That's a good question. You know, we tend to have performance measures that focus on pediatric populations versus adult populations. There may be an occasional measure and for example you could have readmission's measure that includes all age groups. And so I think, you know, we certainly can, you know, look at these issues in terms of are there special circumstances where these things are included or not included and how it relates. So, I would just say that pediatric population is certainly in – in the scope and we – we will, you know, definitely want to consider how that should be included in the scope.

Alyna Chien: OK, thanks.

Karen Pace: OK, so as the first part of the memo and we'll probably continue some of this discussion was setting out some definitions and we went to NQF sources for a

lot of these but I'll just mention and point out as you see on your screen with health care disparities, I had Kevin reminding me that we have an NQF definition that I haven't put in there initially. So, you'll see that in that track changes on your screen and, you know, the suggestion was that since NQF has done some prior work and quite a bit of work in this area of disparities that we should be consistent in using that definition.

So, we'll definitely put that in there and use that as our primary definition but certainly if anyone else has any thoughts about that or any of the definitions, we can, you know, certainly have a discussion. Or if there are certain other definitions that we have not yet identified that we should have a standard definition, so that we're all – all in the same page.

Kevin Fiscella: Yes, this is Kevin. I just want to point out that I think this is an important issue and worthy of – of some thought and reflection because it does bear on some of the issues that some of the members have already raised regarding scope and whether this is narrowly focused on – on SES and/or race and ethnicity or whether it's – it begins to address other aspects of social disadvantage such as low health, literacy, and language, etc.

Steven Lipstein: So, this is Steve –

Kevin Fiscella: Or any for that matter.

Steven Lipstein: This is Steven Lipstein. I was going to weigh in here. As – as we went around the panel introductions, a number of us have experience within the health care sector, and that's the focus of our research area but important here is the whole discipline of human behavioral economics which is the discipline of basically says that people can't reduce risks or eliminate risks, they avoid risks.

And as that it relates to – to the assignment before us, there are examples of outside of health care that might help us. So for example, many of you are familiar with testing in public education and public schools that are not risk adjusted for socio-economic factors or – or single parent households and there's – there's evidence that would suggest that really, really good teachers after they've worked hard to reduce and avoid risks in intercity public schools,

once they realized they're just going to continue to be evaluated on unadjusted test scores, end up migrating to school districts with better socioeconomic profiles. So and the same is probably likely to happen in health care and so when we get to page five, and we talk about divergent use regarding socioeconomic status and risk adjustment models.

One of the diverging views we have been pointed out is that the absence of those risk adjusters is increasing disparities in access because human behavior is going to be dictated by risk avoidance. So, I hope we can – we can learn from models outside of health care so that it informs our recommendation.

Karen Pace: Sure, and certainly if you want to share any particular reference from materials regarding that we'll be glad to include those, but I think that you're right. That is definitely one of the consequences that people are concerned about in this space. So, definitely we should have that in the discussions.

Norbert Goldfield: Thank you. This is Norbert Goldfield. I would add on page four, when you talked about items. There's no (real) mentioned is there – there's a document of patient engagement, patient empowerment, patient (activation). Those are particular relevant for adults to the whole pediatrics that are (turn). I think that's what I – the comment before on pediatric versus adults is important. But it seems to me that the document has very important quality outcomes mentioned for example on the topic on page four but I would have a separate bullet because of the fact of the rapid advances that we've seen in the literature on patient engagement activation and (empowerment) that frankly also have implications. We'd be here to look on this.

Karen Pace: Certainly, and just to add a little bit about that, NQF had a project in 2012 on patient reported outcomes and actually, you know, and we can certainly call that out under that section but a lot of those patient activation and patient engagement, shared decision-making were identified in that realm, but certainly it's worthwhile to actually have them called out.

So, thank you.

Atul Grover: Hi. This is Atul Grover. Just one thing I wanted to throw out there as we think about now or later broadly defining SCS. I know that in dealing with

our institutions, one of the other issues that often is (waste) – is the issue of having dual diagnosis with mental health issues that tends to affect a lot of outcome measures such as readmissions and, you know, again, not sure where we want to consider it in all this, but I didn't want to wait until last minute to bring it out and just bring it on people.

Karen Pace: Right. So, that's a good point and probably I guess I don't know if you would consider that as kind of this expanded area of disadvantage populations or …

Atul Grover: I think so.

Karen Pace: OK.

Susannah Bernheim: This is Susannah Bernheim. I think the challenge there is part of what you try to (lay) and this document is sort of what is clinical status versus SCS and when you get in the dual diagnosis realm, you're certainly talking about a really vulnerable population group but it's less controversial about whether those kinds of issues that are clinical would be appropriate for risk adjustment for a measure where they were important and it may be useful and I think – I'm sort of echoing what Kevin said.

I think we should try to be as clear as possible about what a potential risk adjusters we're talking about. I also recommend we don't spend endless time deciding which of them is the most important because I have gone down that path as I'm sure many of you have. But if we can (bound) what's in or out. You know, with (raise in), is it not in, is (inaudible) not in and then be consistent. I think we can move forward.

Tia Goss Sawhney: This is Tia speaking. Certainly, mental – behavioral health, mental health, substance abuse et cetera are reflected in the – in the clinical portion of risk adjustment. What we might want to do those consider the possibility of interaction effects between the – between them as a clinical parameters in socioeconomic status.

Karen Pace: OK. And I think – this is Karen. We'll definitely need to be try – as Susannah said, I mean, there, you know, we could get into a long list of potential factors and I think at some point, we're going to have to, you know,

find the right point conceptual versus very specific recommendations because obviously in the period of time we have for this projects, we won't be able to, you know, thoroughly analyze every particular type of potential risk factor.

And some of these risk factors are specific for certain outcomes. So, I don't have an answer to that though I think the caution is worth of all us considering what we can accomplish in this project.

Norbert Goldfield: Again, this is Norbert Goldfield again. One (access) of classification that might be helpful – the two actives that I want to highlight, but most importantly is the availability of data and for example there's a fair amount of claims data that people's – some clinical information and there's data that is routinely available for some types of encounters such as health status, some – even nursing homes or from home health care and then there are other variables or that could be available that are likely to be available.

So, I think there's one access of classification that could be acquired to the different list that are going to be – list of possibility items to be considered of this, how available are they, how available are they likely be and within two years or within five years, the new – so that's one access of classification.

The second access of classification is one that you just highlighted which is which outcome are you thinking about and clearly some hospital outcomes are very different from outpatient outcomes. So, I think we have to hope to also be clear that a good – which outcomes are we considering but I'm very much in favor of this – of the cognitive of this – of the (first) access of classification as to which how easily available is the data. Is that available today? If it's available today, then we should use it today. We should not get – or talk about it.

If this is going to be available tomorrow, well that's to get away. For example, we're working several states now on finding the word homelessness. What is the word homeless mean? And so that (affect) data is going to be collected as these next (succeeding) months so that's great but then the other data such as station acquisition that may take longer.

So, I think that access of classification is potentially useful.

Karen Pace: OK. All right.

Nancy Sugg: This is Nancy Sugg. I just wanted to make kind of un-extended comment regarding that. When I have a patient that is homeless schizophrenic and using cocaine, I really want all these factors taken into account when somebody looks at why I can't get their A1c down, but on the other hand, when I looked at how do we extract these pieces of data and how easy is it to get them from what we already collect then it becomes a little more daunting.

And so one of the things I do want to make sure we keep in mind is, what is the cost in technology or in data gathering that we're going to put on different organizations, community clinics to say, "Well, now we want you to pull out all these specific things about your patient and then we're going to throw them into risk adjust." And I just want to make sure that we're very conscious of the cost of that technology to clinics.

Karen Pace: OK. Thank you all for those comments. I'm going to take us back to the memo and just to ask if there are any other definition – any other terms that you feel that we need to define as a basis for our work and then we'll go onto some of the key questions that we want to address. We can always come back to these. I just want to see if there are anything that is off that we missed. OK.

David Hopkins: Hey, Karen. This is David Hopkins. I'm thinking back on my training at Intermountain Healthcare, you know. (Brent) seems always said the cost as an outcome.

Karen Pace: Right.

David Hopkins: Have we indicated that?

Karen Pace: Yes, yes. We have economic outcomes as the category and we would include both cost and resources in that category.

David Hopkins: Great, thank you.

Karen Pace: OK. So one of the things that we, you know – and it's already been pointed out that we talked about at least two divergent views and had some discussion about the consequence related to risk avoidance that we can work in here. But, and, just a couple of things that I want to mention that there are lot of already kind of established perspectives and positions on this and one of the things that we really think we need to do in this project especially at the in-person meeting is really kind of look at those head on, have people really state their perspective and also for us to identify some basic core principles that we can all agree to so that we can move forward from there and also go back to those if we run into some rough spots.

It's not necessarily a foregone conclusion that the recommendations will be to risk adjust and, you know, again, we have to kind of decide what that means. There are multiple ways to potentially approach the issues and concerns that have been brought up. But one of the things that we did was try to identify some core principles that we thought would be – had pretty widespread agreement that would service a baseline, but definitely that, you know, interested in other spots.

And the whole point of that is there's a lot of – there can be some implicit assumptions that go along with different perspective and also, you know, part of our work we'd like to ask people to kind of suspend judgment until we really together examine a lot of the issues and the pros and cons. So I'm going to just stop there and see if you have any thoughts about the core principles and how those are affecting various things at this point in time.

Dave Nerenz: Dave Nerenz here. Actually, just a little higher up on the page where we talked about the two divergent views, I think those are actually stated. But it actually didn't occur to me until just now. It might be helpful to the group if official written versions of those if they exist would be circulated just so we can see in original terms sort of how those views have been expressed and with what rationale and in what context.

One thing I've observed in trying to track this down a little bit is that occasionally one stated view will be cited by someone else and then in turn cited someone else and there are often some new ones and settle this that

make it launch. So I would actually be interested if as part of our background material we could be whatever written expressions of these divergent points of view exist.

Karen Pace: OK, thank you.

Gene Nuccio: Karen, hi. This is Gene Nuccio from Colorado.

Karen Pace: Yes.

Gene Nuccio: On your second bullet under core principles, the parenthetical phrase there or statement regarding inclusion or not inclusion as risk factors is one element in risk adjustment. But the other element is how one might go about applying these predicted values to the performance of a provider to adjust either up or down that once relative to the patient's provider serving. So I think that we need to know not just inclusion or exclusion as a risk factor but how the model or final model gets applied to adjust the performance.

Karen Pace: OK. OK, I'm just taking notes here.

Sean O'Brien: This is Sean O'Brien. This is a pretty minor point but I would consider changing in that single point changing risk adjusted to say adjusted for differences in case mixed because there's different ways of approaching case in expiration. And often in risk adjustment people think of progression analysis and they contrast that with stratification in the context of the SEC adjustment their recommendation is use stratification instead. And I would just say that stratification and progression modeling there's other approaches for all kind of within the bucket of adjustment or (case next).

Karen Pace: Yes, that’s good. That is a broader way to talk about it, thanks.

Nancy Garrett: This is Nancy Garrett from HCMC again. (Inaudible) we're talking here about individual patient factors of health status and socio-demographic, but do we also want to think about community factors and the influence of the social context on individuals?

Karen Pace: Could you talk about that a little bit more?

Nancy Garrett: Sure. So, you know, kind of basic principle in sociology is that you can be influenced by your own (inaudible) but then also by those communities that you live in and that can be defined in a lot of different ways everywhere from the block to the country. But do we want to consider characteristics of those communities, so people who live in high poverty areas might be more at risk regardless of their own individual characteristics, or is that going to be beyond the scope of what we can do here?

Karen Pace: No, I think it is. I just wanted to make sure I was understanding what later in the document we talk about which I can of have in the more message area but may be you're thinking of it differently, you know, other used individual risk factors or community level and this kind of also may relate to availability of data and what's practical, so are there community or hospital or organization level factors that describe the patient population without getting into patient-by-patient characteristics. So I would say that on the table I just wanted to hear more what you're thinking was.

Steven Lipstein: Yeah. This is Steven Lipstein. Can I just endorse what the previous person just said, because there is recent work suggesting that people who live in high-vacancy residential neighborhoods where there is no social infrastructure, no transportation, no grocery stores, no drugstores, no taxicabs and we do know everybody's address so we do know who is this in high-vacancy residential neighborhood. And there's evidence suggestive that individual income is not nearly as predictive as people who live in those kinds of circumstances.

And so I think it's critical to our work and a lot of this has yet made into the peer review's literature for whatever reasons. But it is emerging that that you can be poor and live in, say, Chapel Hill, which is a high-density area, and you could be poor and live in the boot hill of Missouri with the same income and have very different clinical outcomes related to your life circumstances.

Nancy Garrett: Yeah, exactly. This is Nancy Garrett again. So for the first principle under core principle, we might want to broaden that to not just talk about patient factors but also community and organizational factors.

Karen Pace: OK.

Male: Karen, on this …

Male: I would just endorse that idea as well, because if you think about how some institutions or providers end up looking better in terms of their outcomes with some of these patients despite having individually challenged patients, if you find that there are other community resources that are put into play that lift all (votes) so to speak and so you'd find the state that even you get pockets of poverty but it does relatively well and better than average for the nation.

David Hopkins: Karen, David Hopkins again. With reference to the second principle, the second bullet here, first of all I want to endorse the concept that risk adjustment is a more comprehensive concept including stratification. But separate point, I'm catching on the word "fair" here – fair comparisons provide a performance, fair to whom. Do we have a definition of fairness? Do we consider the other side of that which is, you know, having not adjusted a way so much that there is no opportunity for the patients to make decisions?

Karen Pace: OK, that's a good point. And I think just to say, I mean, we definitely want to examine all of the perspectives on this in terms of, you know, what are the consequences one way or the other. And the idea here is to agree in some principles and so, you know, the thing is that, you know, the second and third bullet might be viewed as kind of competing principles or priorities. And one of our challenges might be to try to navigate to figure out the best way to accomplish adequate performance measurement as well as deal with identifying and reducing disparities then I think along with that as people have already mentioned not increasing disparities.

David Hopkins: I think that's right. My point was more about accountability applications and particularly public reporting, which after all as Nancy gave information out to these patients about where they may seek better healthcare.

Karen Pace: Right, OK.

Sean O'Brien: This is Sean O'Brien. I thought I was just – excellent point. I think the wording to the extent that we can use more precise wording with less values build into it in extent. In this case, I might think that the reason that outcome performance needs the risk adjusted is to avoid inferences in terms of the

information that the data provide that from a physical perspective are often basically trying to address (inaudible) question if the group of patients have been treated by provider A or provider B which provider would had better outcomes or which provider with those patients had better outcome.

And so it's kind of – if you approach from that perspective you're asking specific kind of hypothetical question and that's where you find the data enough to – that's the reason risk adjustment is needed if you go to answer that type of question.

Karen Pace: OK.

Alyce Adams: This is Alyce. I endorse that as well. I'd like the idea of a different – fair has too many meanings that hated too many people and that framework I think helps.

Karen Pace: OK, that's good.

Tia Goss Sawhney: This is Tia. And the outcome performance measures needs to be risk adjusted. I'm there with you and I agree with the second part about provider for performance – provider performance for accountability application. The risk adjustment is used in other context, too, and the big one I'm thinking about is it's used to adjust payments made to insurers or between insurers, Medicare adjust payments, Medicaid adjust payments. And under Obamacare, there's risk adjustment between insurers operating on the exchanges and socioeconomic could well enter into those risk adjustments. So I think we need to somehow say that that's just more than provider performances being measured. It could be a system outcome measures.

Karen Pace: So I think that's a good observation and I'll just say that may be an area that is a little bit out of scope for us, because NQF really works in the space of performance measurement. And so you're absolutely right that risk adjustment in often used in setting initial payment rates or base payment rates or adding to base payment rates based on the case mix of patients you're serving and may include some of these factors. I don't think we can actually make recommendations in that space, but I guess certainly if that's going on it

may have implications then for how we view whether risk adjustment is needed for performance measurement.

So I think it's related but it will – we really can't make recommendations about payment method – in those kinds of payment methodologies.

Tia Goss Sawhney: OK, good to know. The other thing – one more point, if everyone will tolerate it, is that I think it might be useful to have the fourth bullet point it's not – you've all – several of you have brought up the issues data availability, data reliability, the consequences of action versus inaction, doing an adequate job in risk adjusting because we'll never do a perfect job risk adjusting and competed interest. And so, kind of is there some way to (inaudible) single-sentence bullet point that wraps it all? Basically, it says we'll keep our feet on the ground in this process and understand that there's trade off and limited data and you don't try to come up something hesitate to use the word practical.

Larry Casalino: This Larry Casalino. I just want to go back to the point that was made a couple of minutes ago, you know. The performance measure, as we all know, can be used in multiple settings and for multiple reasons, right? I mean, they can be used to make capitated famous to health plans, they can be used and pay for performance programs, they can be used for public reporting, they can be used for internal quality important and so on. And it may be that the type of risk – both the type of risk adjustment you do and how it's played and what you do with the risk adjustment differ by the shedding/purpose/program in which the risk adjustment would be used or not used.

I think we may have a problem going forward if we talk generically about risk adjustment and I may be talking about it having in mind, you know, public reporting and the next speaker may have in mind risk adjusting for famous to health plans, another speaker pay performance and so on. It might be important to try to take the different settings or types of programs in which it can be used individually. I'm not saying now but going forward and talk specifically at first at least in that kind of program what if anything do we think should be done and then may be take it up to a higher level from there.

Marshall Chin: This is Marshall. I want to follow up on Larry's comments and I guess a couple of speakers before Larry, you know. I think that really is the (crops) of things that, you know, somewhat NQF (inaudible) performance selection and performance recommendation. But if we don't somehow either go beyond that or we put it in the content as Larry is saying with how the measure is going to be used then we're not going to get anywhere that with two diversion views my guess is that most people here on the call would agree that both are valid.

But from the (inaudible) issue of how they will be used then it's dangerous in some ways to come up with sort of single standard of what should be done. So I think that in some ways if we totally punt them at we'll just not going to get anywhere. So may be if we can some clarification from the NQF folks about the scope of our – what then we can do in a particular I guess like came back to Larry's question about, I think at a minimum we would need the patient be able to think a different scenarios under which case adjustment will be used, what principles we think would be more appropriate for given those scenarios as well as (inaudible) waiting to policy, you know, to find a byline about some of the actions or else safeguards to prevent appropriate use and preventing a misuse of case mixed tools.

Susannah Bernheim: This is Susannah Bernheim. I know you asked for Karen (on the way) and I just want to add one thought I have about that, which is that I think that this differentiation between the different potential implementation of the measure, they use this on the measure. Or this topic is sensitive because we all have a sense or many have a sense that only are safety net providers caring for population of vulnerable patients. But they, as providers, are often more at risk for financial vulnerabilities and so the whole think gets more heightened if there's a financial impact. So I agree that talking about how you might think about this differently in pay for reporting versus pay for performance program would be valuable.

Monica Bharel: This is Monica Bharel, Boston Health Care for the Homeless. I just want to add to that that, you know, on the ground in Massachusetts in the Medicaid capitated program that's being worked on right now. There are two ways in which risk adjustment has come up both of which have been alluded to, and

one is in the realm of quality where the XCG is being looked at and one is in the PMP on monthly payments in which (Pcal) is being used. And then both of them we have brought to the table this issue around risk adjustment socioeconomic factors.

So this discussion is relevant because the issue of risk adjustment socioeconomic concept in both places, both the quality and the payment issues and it's very timely. So I think we should have some clarification on that.

Karen Pace: This is Karen. We do have that as a key question. The different accountability applications required different expectation. And I think, you know, that is something that's on the table for the expert panel to discuss. And the challenge will be really the rationale, so ultimately if you have a reliable and valid indicator or performance the question is what's different about using a reliable and valid indicator in pay for performance versus public reporting, you know. We definitely have to work through that and clearly lay out the rationale of why there is a difference and what implications that has.

Male: And, Karen, I thought we'd come up with some good wording in the page above where you wrote in something about avoid incorrect inferences that …

Karen Pace: Right.

Male: … isn't that the principle that we're all screened to …

Karen Pace: Right.

Male: … regardless of application?

Karen Pace: Right.

Pamela Owens: Karen, this is Pamela Owens from AHRQ. And I think along I totally agree with what everyone had said so far, but really concretely above the assumption values and core principles the third divergent point is that stratifying for SES actually allows for disparity. In other words, it's OK that the quality of care is different for different population. But I think that has to

be taken and stepped further which is the application of that in the various programs and purposes.

Karen Pace: Could you say a little bit loud? So I think you're getting at – what we were trying to convey in the second one was that adjusting should not be done because it obscures disparity and implies, you know, basically status quo is fine. But what are you saying about how that's get implemented or …

Pamela Owens: It's not adjusting for SES, but now stratifying for SES. It highlights that there are …

Karen Pace: Right, right, right, right, right, right, right.

Pamela Owens: But in some it implies through some people that those disparities are okay.

Karen Pace: Right, okay.

Pamela Owens: In my mind that's, again, it's about interpretation and it's the application of identifying those disparities.

Female: And the question would this (inaudible) statistical model that the outcome measures tend to be based on is how you would stratify is actually important to think about because it's not as straightforward as it is with things like (process).

Karen Pace: OK, all right. So may be we'll continue on about – well may be we'll go down to the next set of core or key questions. And, you know, the purpose of this project is not necessarily created definitive casual pathway but things that certainly have some implications for potential recommendations so that did want to think about how we should discuss this or frame this. But, you know, for example if the socially, you know – however we decide to use the term social disadvantaged populations, if this translates into them having poor health status the question is, you know, do clinical and health status risk factors accommodate or actually account for a lot of those differences.

However, you know, if part of the mechanism is not even getting to help services to begin with, we may not even have those kinds of information

available at the start of a care that someone has had, you know – they may not even know about their existing conditions and comorbidities. So I think, you know, interested in your comments on how to consider this without again getting too far in the weeds or down this path where this could consume us.

Larry Casalino: This is Larry Casalino. One thing that occurred to me in looking at figure 2 is, you know, it makes a lot of sense. I'm sure people will have comments but I won't as applied to an individual. But I think it raises the question – so this is to me a conceptual model that looks at the effect of such demographic factors in an individual on outcomes. But I'm not sure if we're going to be talking about risk adjustment based on the population and organization it serves. I mean, when you started doing that stratification it seems to me that you could be talking about that.

So if it's an organization that takes care of a very poor payor mixed, say, and the patients that are very difficult to care for then that organization will have a fewer resources to put into improving the quality or controlling cost. And the question is should that be allowed for or should that in some way, you know, be adjusted for or shown a stratified analysis or what. So one question is do we care about that? In other words, if an organization has a worse less resources to improve care because it has a population that is low as (it has), do we care about that? And the other is if so, does this model work in figure 2 or this is the model only work for individual?

Karen Pace: Right. That's a good point and I'm going to ask Kevin if he might want to make some other comments related to that. I know you shared some things with us along this …

Kevin Fiscella: Yeah. I actually agree with Larry's point. So let's just take for a minute the issue of low-English proficiency and people who need language interpretation. And so we know that doing that will involve longer business. It's more complex and it involves greater need which costs more money. But yet if you're in a safety net institution with limited resources, you have less resources. On one hand you have a greater need, the need to provide language interpretation for us the entire continuum of care, not just one (stick) of time but the whole course of the person who understands what's going on.

And at the same time, many people with low-English proficiency are being served by safety net institution who may have limited ability to pay for those language services. So it's really the intersection I think between the resources at the system level and the healthcare needs at the population level. So yes, I would add an additional box there that looks at the provider level, what those resources are that available because of that intersection between the two.

Karen Pace: OK. And some of these also I'll ask you to think about is, you know, there have been studies and empirical analysis about some of these questions, you know. If you have certain factors in the model already and then add socioeconomic status, how much more does it really add to the model in explaining variations. And so if you think of or have done any of those kinds of analyses, certainly, you know, again there are references that you want to alert it to, we'll be glad to get those.

And let's see, continue on here. I think a question that sometimes comes up in this context as well is, do all providers serving disadvantaged populations invariably have poor outcome performance? Someone made the comment earlier and related this back to community resources and community activation, for example. But what implicate, you know – first of all, what's the answer to that question if anyone knows? And I know, for example, Yale has done some analysis with their measure in this regard and possibly MedPAC. But you know and what implications did the discussion of that question have for recommendations?

David Nerenz: Dave Nerenz here. I guess the word "invariably" is one that I circled in looking at the draft that seems kind of a high-(variant) word …

Karen Pace: Right.

David Nerenz: … discussed. You know, we don't really expect any class of providers or any setting to be invariable in their performance. I think we're – we're interested in how distributions overlap or don't overlap or how the inference is made about providers are either bias in some sort of a – a way by the – either the inclusion of SES factors or not.

You know, the question is post there where I guess is OK, but I think I'd rather try to answer it without strict regards to the word "invariably." I think we should …

Karen Pace: Right.

David Nerenz: … think on average or typically or …

Karen Pace: Yes.

David Nerenz: … what are the distributions look like compared to other distribution.

Karen Pace: OK.

Tia Goss Sawhney: This is Tia and I'll second that. I mean it's the – it's a question of what outcome and how are you defining disadvantage. A classic example, Hispanics on – In Medicaid populations of Hispanic – of Hispanic women who are very poor and are very often undocumented at least in Illinois had very good birth outcomes. So, I mean it's – yet they are disadvantage, you know, so, but they don't do as well in other outcomes so (often).

Karen Pace: Right. Right. Right. And I think that's a good point again. It's not just the type of outcome, but the actual outcome and probably relates back to – to just general principles about selecting risk factors. So, if a particular risk factor really isn't at play for a particular outcome, it should be considered whether it's in this category of disadvantage or clinical, but you know, that's a good point.

Susannah Bernheim: And Karen. This is Susannah Bernheim again. It makes me think that likely this committee's recommendations will need to be more about how to approach this question for any given measure and some guidance as opposed to an absolute this is what should or shouldn't occur in these measures.

Atul Grover: Yes. This is Atul. I also think that, you know, any way that we can look at interventions that are occurring outside of that provider-patient interaction at the state or community level ought to be measured. Because again, I think that, you know, poor people are different in one city and are treated differently

than they are necessarily in another city in terms of the resources that either the city or the state at the (size) for (inaudible) or in some cases.

You know, if you – if you look at the place like Denver Health that's – that's worked on some interventions as a provider, but done that for decades how does all that factor in because ideally I think not only do you want to give people (about) kind of information about how they ought to be thinking about how these different factors affect patient-care outcomes, but also what are the interventions that can improve those outcomes in the long run whether they are interventions done at the provider level or somewhere else.

Nancy Sugg: This is Nancy Sugg. So, I think that again it's that one size fits all that kind of worries me about this because part of me really wants to see what are the differences between what happens to somebody who has certain characteristic in Seattle versus Denver versus Boston because it will then enlighten me about potential little things that I could do here to make things different, but at the same time when it comes to paying individual clinics or individual providers based on that comparison that makes me very worried. So, I really do feel like we have to break out in some ways categories of how we would use these different risk adjustments.

Steven Lipstein: Nancy, you should – This is Steve in St. Louis. Your worry is well found because as Atul mentioned how we resource safety nets in almost every city of United States is a little bit different and if you have a local property tax or sales tax or used tax that underwrites services to disadvantaged populations and you contrast that with many rural communities that don't have those – those local tax bases to support services of vulnerable populations.

These comparisons while they are interesting because you – you can see what works in an urban community versus a rural community versus one with a high-tax base versus one with no-tax base. When you – When you – When you adapt those adjusters into policy and payment mechanisms, that's when you really get into – into challenges I think. So, it's a really good worry that you're – you're articulating.

Kevin Fiscella: This is Kevin. As – As we go through this exercise, it reminds me that we're likely to be addressing a series of questions and the first question is sort of the generic if in other words should we ever adjust for social disadvantages SES-based necessity and so on and then followed that.

If so, if we agree that at least in some cases then when, where and ultimately I think there's a how and I think early on I think it would be – it would be good to hear if there are members who – who really don't think that we should ever adjust and put that out there. And – And if so to weigh in and provide – provide references that the committee should decide.

Lawrence Casalino: This is Larry Casalino again. So Kevin, this is for you and David and the NQF Leadership. I mean – I think this is a very practical kind of agenda setting decision for the (in-person) meeting. You know, basically say what I said again and they were – they're what Marshall said I think more eloquently which is Marshall used the word "scenario," but it might not be an efficient use of our time in person.

If, you know, if I talked about capitation payments to providers or health plans and know it should be risk adjusted and then – and then somewhere else brings out the discussion that we just had a (moment) of safety net clinics and so on and so forth. And I wonder if it would make sense to try to spend part of the day on a limited set of – of categories of scenarios in which performance measures might be used and then to discuss risk adjustment within each of those scenarios whether it should be done if so how.

And then I guess a question which may have already been answered I'm not sure is that all we do is say should it be used or not and how or make any comments at all about if it is used, how it might be used in the sense of a display of information or what we think are – are more or less better ways to pay for performance say based on the form of risk adjustment that we recommend or not.

Kevin Fiscella: Right. That's really two – two comments. One is saying that we may want to explicitly make a limited set of scenarios and talk about indifferently. The other is the question that came up a while ago I think which is "Are we limited

to saying that whether or not we think risk adjustment should be used and if we think it should how" or also say and by how I mean methodologically how things can be risk adjusted or stratified or whatever, but that shades pretty quickly into what might be done with the risk adjustment. For example if we say "No, don't risk adjust show stratified analysis," that is hard to separate from how or what the data to be used if you see what I mean.

Karen Pace: Yes and this is Karen. I'm not sure that making specific recommendations for example how the measure will be used and pay for performance that I think is out of our scope. But obviously this is one of the things we struggled with all the time is the performance measure and then how it's actually put in to use. So, it's a good – good question and we'll have to figure out how to straddle that line.

Marshall Chin: This is Marshall. That's for example Sean, David I think a couple of others on this call were also on this recent NQF Panel on trying to come up with disparities of the measures. So, we had to come up with something in order that – sort of a restriction that you mentioned about being selecting performance measures, but at some ways there was a quite artificial exercise and you know really limited in what it could really do because it (then) get it to the next step of well how would this be used then the (contester) use then different I guess more specifics about other than what, you know, an AA disparity measure exists.

And so, you know, I'm afraid we're going to have the same route here where we come up of something, but you know, in terms of practical use it could be not that helpful because it really is not taking a realistic look at the factors that go into why you would or would not want to risk adjust a measure. So I think that, you know, if we really want to have an impact, we do have to think about, I think Larry was starting to do it very nicely this fine line between what is acceptable with an NQF charge, but we just push the envelope so it's not just (at home) about – about the theory of risk adjustment.

Nancy Garrett: Well, this is Nancy Garrett from HCMC and I was on the Cost and Resource Use Panel this year and you know, we have a lot of discussion about well, should we include a variable that would indicate (dual-ability) status and

therefore that would be an indicator of SES, but that's actually against the NQF Approach right now and so we really can't do that and so, we were actually using that as a criteria by which we are judging the measures.

So, I actually think that if we came out with a clear direction of whether or not it's acceptable and desirable to risk adjust for SES and these other factors actually there might be a lot of progress and insulin is quite a bit of the measure developments based on what I've seen.

Lawrence Casalino: This is Larry again if I can just jump in. I guess it means a little bit what we mean by risk adjust, right.

Nancy Garrett: Right.

Lawrence Casalino: If we say risk adjusting variable into a multivariate regression, right and then if it's OK, we're done. Then, we've obscured abilities to – to a look at things in a stratified way and which truly helps us understand them more and we also may be rewarding providers who – who perpetually provide worst care to low so yet – low SES patients. You are all familiar with the arguments.

So, on the other hand, the argument is to do that to throw a risk – a risk adjuster or many risk adjusters into multivariate analysis. If we start saying "No, no, no, no, you need to do it in a stratified way" again I would say the question is really in what scenario doing it in a – you do in a stratified way, but it's hard for me at least to separate saying "Yes, let's risk adjust by showing things in strata." I can't really separate that from what gets done with those strata and …

Karen Pace: Oh.

Lawrence Casalino: … – and in what kind of scenarios and that's why I realize NQF is in the business of – of many measures and not telling people how to use them, but in this case, it – particularly when you start talking about stratification, it may be a little, the line may be blurred a bit.

Karen Pace: Right. And you know, stratification as, you know, people have talked about does not have to be within a provider setting. It can be other ways of thinking about stratification and use, but I'll just ask Larry and others who have weighed in on this if you could and I think that's an excellent idea that we have to look at some actual scenarios, but for example how would you see using – how do you see that say a measure that's going to be used to publicly report versus in some pay for performance program, what are the differences in terms of expectations of reliability, validity and therefore risk adjustment for the, you know, making the right inferences in terms of the difference between those two accountability applications.

Lawrence Casalino: So, this is Larry again and then I'll set up for (a while). You know, to me, this ample time I had again, if it's pay for – if it's public reporting, then I could see an – an argument for doing a "both ways" for putting information out that shows an organization say takes care of all its patients, but then showing (straight to) patients if the end is sufficient and/or showing how that organization compares to other organizations in its category, right.

Karen Pace: Right.

Lawrence Casalino: So, you kind of do it both ways, you know, as opposed to having to choose one or the other. You know, now, would you do it differently for pay for performance? I mean in pay for performance you can't do it "both ways" in …

Karen Pace: Right.

Lawrence Casalino: … quite the same way, right.

Karen Pace: Right.

Lawrence Casalino: You could have a blended formula where you use some of the kind of absolute score and some of the score compared to its (stratum), but again that's actually as I'm saying that I realize I think that's a good example of how it's hard to separate the method that should be used or not from the use that will made of it.

Karen Pace: Right and I think that's a good point and actually – and you know obviously none of us have (thousand) visits to a great extent, but in that scenario, you could be using the same performance measure computed exactly the same way, but applying it in different ways, you know, like you said for public reporting it, maybe reporting it multiple ways, but in pay for performance actually using that computed performance measure in some other way like, you know, organizational comparison groups, et cetera. But so, I think, you know, I think we really do need to, you know, try to sort that out.

Female: And that last example that you gave where you calculate a single way, but then apply the performance, the payment by strata is essentially what MedPAC has recommended and I think it's that's play an important document for people to be familiar with because I think it's relevant for this conversation.

Karen Pace: Right.

Female: OK.

Kevin Fiscella: This is a – This is Kevin. You know, I'm intrigued by Larry's suggestion about discussing specific scenarios and categories and you know, I wonder about all of us including Larry, all of us thinking about what those categories might be and you know submitting them because that may be one way to begin to make this a little more concrete and discuss it in a more practical way in the sense that I think Marshall was alluding to earlier.

So thinking about what those scenarios might be whether it's, you know, a continuum of care or you know, hospitalization measures whether it's – whether it's for accountability purposes and public reporting or whether it's for pay for performance or whether it might even be used for some other purpose such as a case-mixed payment.

Male: If it's another background …

Kevin Fiscella: That really isn't part of our scope, but we have to be cognizant that some of our methods might be – might be used in that way.

Male: You set a background paper that for the prior disparities measure panel, Joel Weissman and Joe Betancourt and their group. They have prepared a real nice background paper that discussed in more detail or in areas that went beyond I guess what traditionally do you ask what committee can do. Their background paper raised some of these issues and that may be another paper that'd be worthwhile to email up to the group or put on a SharePoint as background.

Karen Pace: Right. Thank you and it is one of the things that's listed in the references and actually what we can do is have all those things available in SharePoint so that people can ease – readily access them and look at those documents. So, we're working on getting those moved over to your – what's accessible to the expert panel and SharePoint.

Sean O'Brien: This is – This is Sean. I'm just going to suggest in addition to enumerating the various contexts in which measures may be used in reporting could we try just looking at a couple of case studies of, you know, maybe measures that were submitted for NQF endorsement and that would give us some kind of concrete examples to help make the issues concrete.

And I think when I've looked at various NQF Measure Submission Form, something that frequently occurs to me is that hardly there's on general very little information is given about the intended use or the intended interpretation of any measure just kind of reflecting the comments that I've heard and particularly there's – I've never seen measures authors go to great length to develop a real articulation of its kind of a theory of attribution and accountability and so just to have, you know, recommendations led to more suggestion to have for measures that are being developed, more discussion and unpacking of the intended use and interpretation that would kind of provide the framework for decision making about, you know, may be the case or some purposes, it does make sense for risk adjustment to proceed in a certain way and other uses it doesn't. So, I think just one looking at a few examples would be helpful in – in general trying to encourage a little bit more concreteness about the intended uses and interpretation measures when they are submitted.

Female: Good.

Karen Pace: That's a good point and actually David and Kevin have talked with us about just that idea of a couple of case studies so we can kind of look at that in conjunction with Larry's suggestion and see what we can accomplish at the meeting.

Nancy Garrett: This is Nancy Garrett. I think the case study is a great idea. We'd definitely do that. I think the challenge is that NQF endorsement is binary. You would see they're endorsed or it's not and once it is endorsed, it's kind of out there in the world and to put restrictions on its use is very different than is I think the current (inaudible) process so that's a challenge.

Karen Pace: Right.

David Hopkins: Yes. This is David Hopkins. I agree with that. I am concerned about the scope expansion that's implied by a lot of this discussion.

Karen Pace: Good points. We'll have to work on making sure that we stay within scope, but you know, there may be short term and longer term recommendations as well so and some of those may involve suggestions for NQF Endorsement Project and I don't say that that's totally off the table obviously in the short term. You know, things cannot change on a time and that would entail much broader discussions with our board and membership, but certainly, you know, we – we would need to kind of think about that and in terms of a longer term or future recommendations that might be on the table.

David Hopkins: You know, my question was more about the function of this group versus others that I think are already starting to look at issues around use of measures, Karen so.

Karen Pace: Yes, yes, good point.

David Hopkins: If it just – I mean it applies to NQF across the board.

Karen Pace: Right. OK. So, I think what we'll do is ask if there's any public members or NQF Members on the call that want to make any comments for the Expert

Panel to hear or and staff so the lines should be opened and we welcome you to just identify yourself and raise your thoughts.

(Ann Page): This is (Ann Page). Actually, I have one.

Karen Pace: Yes.

(Ann Page): For all of the reasons that the committee has already discussed this afternoon, might the committee in formulating its recommendations think about presenting the issues of risk adjustment in sort of a – in a different way so that it's – it's not presented as an all or nothing binary approach, but rather communicate that there is risk adjustment, there's partial risk adjustment, there's some gradations at risk adjustment so that it would just be clearer to audiences that when a measure is presented as being risk adjust, it's not adjusted for every variable known to affect performance, but to change that paradigm a little bit so that people don't think it's a yes-no binary activity.

Karen Pace: OK. Thank you.

John Shaw: Hi, Karen. This is John Shaw from Next Wave in Albany and I very much enjoyed the discussion. A lot of the issues that came out had also come up in discussion recently on the QMRI Council responses to the Medicare spending for beneficiary measure, which I might suggest as a possible case study to look at.

And I think it also mentioned some of the readmission measures and the reason for that is the issues that are really driving variation are the social determinants that really come to the (four) when we look across time longitudinally starting with the inpatient admission and I'm looking at cost for 30 days or readmissions in that 30 days. There, we start relying on what some of the members talked to as what's available in the community outside of the traditional healthcare delivery system, what supports are available and that – becomes particularly important.

A few other things that really resonated is we found that communication of health literacy in language particularly and education seem to be factors that typically show up everywhere when we start looking at impacts on disparities,

although the analysis we did for the CSAC and the QMRI input showed that the top and bottom deciles only differed by about 6 percent on the MSPB measure, but within each of the groups, the variation range was about 60 percent. So, I think the – we're not talking about adjusting a way all of the variation. We're adjusting for some of the variation, which may be enough of the variation to keep some of the safety-net providers alive physically.

Karen Pace: OK. Thank you.

OK. Any other comments from our audience?

(Johnny Hood): This is (Johnny Hood) with (Porter) Hospital and this may be of overly simplistic question because I perhaps just not fully up to speed on this topic, but is there an NQF Measure that's endorsed that measures patient's socioeconomic status? Is there a household income measure that can then be correlated across other endorsed measures?

Karen Pace: No, there isn't a NQF Endorsed Measure of, you know, socioeconomic status or social disadvantages as we've been talking about and I think that is one of the challenges when we start talking about adjusting for any of these is as one of the committee panel members earlier on talked about looking at data availability and what's feasible now versus in the future, but it's a – it's a question definitely something that needs to be taken into consideration.

(Johnny Hood): Thank you.

Karen Pace: OK. Thank you.

OK. I'll just ask if there are any other comments from the panel members and then I'm going to have Suzanne just quickly inform us of next steps and certainly I'll just – and see if – we'd liked Kevin and David to see if you have any final remarks that you'd liked to make to us and the panel. So, any outstanding questions or burning comments that you want to get on the table.

Sean O'Brien: This is Sean I apologize for talking again. Just going back to the purpose and what you ask in the beginning whether the two bullet points out the purpose of the project and it seems to be added …

Karen Pace: Right.

Sean O'Brien: … if I might ask whether we consider having a third bullet point that would address alternative ways of addressing concerns that, you know, the concerns – underlying concerns about the need to not adjust for SES and performs measure that's related to not providing incentives for addressing disparities or (masking) disparities and I would have a hard time proposing to begin adjusting for those variables if we didn't have some recommendations for – for how to address those valid concerns in different way so.

Karen Pace: OK. Great.

All right. Kevin and David, any words of wisdom for us?

David Nerenz: Dave here. I respond to that the way you post the question that's all too hard.

In terms of just a couple of next steps, I think we've had a lot of really excellent important points made during this discussion today. Just to repeat again something you said back quite a while ago on the call, if there are individual committee members who feel that they have some new data where they have a special example of something that would not – is relevant to our discussion, but not – is not already in our background material as we build the agenda for the two-day meeting in January, we like to offer people opportunity to have say something like a 10-minute time block to make a presentation with literal handful of slides just to make sure that the group has in front of it all the possible bits of truly relevant information we have.

The agenda doesn't allow absolutely everybody to do that so you don't feel like there's just a timeslot that you must fill, but I think there are one or two suggestions earlier and some data not yet been put through the publication process that might be relevant. So, if you think you've got a specific point really useful to the group that can be conveyed in a period of 5 to 10 minutes, please send that by email to Karen or Suzanne and we'll see if we can work that in to the agenda for January.

Karen Pace: Thank you.

Kevin Fiscella: This is Kevin. Yes, I want to echo that. That one of the things that Dave and I talked about is making sure that all the voices here on the committee are heard so if you haven't had an opportunity where you've reflected on what we've spoken about and you have further ideas to please email them to – to Karen or Suzanne so that they can be put on the agenda for the in-person meeting.

Karen Pace: Thank you very much. So, Suzanne, I'll let you take it from there.

Suzanne Theberge: Great, thanks. Thank you everyone for your time today. Next steps really involve meeting preparation.

You should have received – panel members, you should have received on Friday an email from our meetings team about setting up your travel and lodging arrangement. If you didn't get that email, please let me know and we'll follow up with you.

We'll be sending an email the next day or so about these panel presentations reaching out to you to see who is interested in presenting and on what. You can expect that soon.

And we'll also be putting out large number of articles and references up on SharePoint for you to review for reference and if you're interested. So and I'll send an email when those are available as well. This should be up by end of the day tomorrow or so.

And I think unless anyone has any question that is everything for the next steps.

Karen Pace: OK. Thank you, Suzanne. So, we really appreciate you taking the time today.

We really look forward to the in-person meeting and wrestling with all of these important issues and the things that you've shared with us and as David and Kevin said we want to definitely make sure all voices are heard and that we really – that you have the materials that you need to make, you know, informed and thoughtful recommendation.

So again, thank you. We'll be in touch shortly and we'll be seeing you before you know it. Thank you all.

Male: Thank you.

Female: Thank you.

Female: Thank you.

Female: Thank you.

Operator: This concludes today's conference. You may now disconnect.

END