NATIONAL QUALITY FORUM
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Meeting Summary

Disparities Standing Committee Web Meeting 6

The National Quality Forum (NQF) convened a public web meeting for the Disparities Standing Committee on December 9, 2020.

Welcome, Introductions, and Review of Web Meeting Objectives

Nicole Williams, NQF Director, welcomed participants to the web meeting. Ngozi Ihenacho, NQF Analyst, took roll call for Committee members. Committee Co-chairs Drs. Philip Alberti and Nancy Garrett also provided opening remarks prior to the review of the meeting objectives. The objectives for this meeting included providing an update on the social risk trial data collection, discussing the survey results, and discussing feedback on draft recommendations for the final report.

Social Risk Updates

Ms. Williams began the meeting with a review of the project goals and recap of the preliminary results from the 2015 to 2017 trial period. The preliminary results showed that over 300 measures were reviewed, with 39% of them including some form of risk adjustment (clinical or social risk factors). Of that 39%, the numbers narrow when considering sets of measures that have a conceptual rationale for including those social risk factors (23%) and whether social factors are included in that final risk adjustment model or approach (11%). The common social risk factors considered thus far include, insurance (59%), Race/Ethnicity (51%), SES (32%), Education (19%), and Employment (17%). There was a mix of additional risk factors considered (12%). Ms. Williams then reviewed key recommendations from the first NQF report of the Evaluation of the NQF Trial Period for Risk Adjustment for Social Risk Factors, noting those that apply to the current work (Trial 2) and help to build the background and rationale. Ms. Williams also reviewed NQF's current guidance on Risk Adjustment as a reminder to the Committee and to serve as a basis for later discussion of recommendations.

The committee members found the overview helpful but expressed concerns about the applications of measures that have been adjusted for social risk and the potential of unintended consequences, such as harming patients or populations that the measures are intended to help or unfairly penalizing providers. Dr. Sai Ma, NQF Managing Director, shared that real-life implications of measures have not been systematically reviewed by NQF, although during the evaluation of each individual measure, use/usability is a specific criterion that is discussed and considered. It was also suggested that case studies addressing the real-life implications be included in the final report.

NQF staff also briefly shared that NQF's 5-year strategic plan will continue the focus on reducing disparities and improving health equity. Dr. Garrett mentioned the previous NQF work on disparities and inquired whether the Committee would continue efforts in supporting any new NQF work addressing disparities and health equity. Dr. Ma noted for the Committee that improving health equity is an important mission for NQF and additional funding is being sought after to potentially support new projects. While it was acknowledged that the current Disparities Standing Committee would dissolve following the social risk trial project, members also agreed it would be imperative to spend their time focused on suggesting strong tangible recommendations for the final report.

Disparities Standing Committee Survey Results

Prior to the web meeting, a survey was shared with the Committee requesting their feedback on three questions: (1) Describe thoughts on the ideal state for collecting, analyzing and using social risk factors for quality measurement, (2) What is their overall recommendation for collecting social risk factors and inclusion of these factors in data analysis in quality measurement, and (3) What are the overall recommendations for measure developers, researchers, and end-users on how to approach social risk factors in measure development and/or the application of quality measures.

The results from this survey were presented to the full committee during the meeting. Dr. Garrett began by sharing specific recommendations from the first question of the survey. The responses to this question fell into themes, which included the standardization of data/collection, inclusion of social factors and further analysis. The Committee generally agreed with the survey results and some of the suggested recommendations. There was agreement on the idea of routinely collecting data on social risk factors, the importance of identifying a standardized set of social risk factors and ensuring that safety net clinics are not unfairly penalized for lower performance on measures that are highly sensitive to insurance status or income (e.g., colon cancer screening). Other results discussed by the committee where agreement was not reached include whether social determinants of health (SDOH) should be treated differently from clinical risk factors and whether disparities should be adjusted for if found. For example, there can be more patients with social risk factors when comparing across hospitals. Some members stressed the importance of examining social risk factors (e.g., SDOH), but suggested not treating them the same as clinical factors given the differences in the root causes of clinical factors vs. social risk factors. In addition, the committee discussed the use of term social determinants of health and social risks, citing that it could be too limiting and that the term is believed to be synonymous with disparities. One committee member mentioned that social risk is connected to disparities, but noted they are not the same thing.

Dr. Alberti shared the survey results from the second question, noting that there was general agreement on the recommendation for NQF to permanently change the evaluation and endorsement process by requesting for and considering and analyzing social risk factors in measure submission.

The third and last survey question and results were shared with the committee by Dr. Garrett. This question explored overall recommendations for how to approach social risk factors in quality measurement. The Committee agreed with several of the suggestions including continued data collection, reviewing how social risk justification can have real world impact, the need for more funding to support developers and researchers, and the importance of stratifying results. One Committee member made a point about how some conceptually significant and obvious social risks fail to show empirical significance in the tests, stating that it warrants a deeper dive by NQF.

Draft Final Recommendations

NQF presented a set of draft final recommendations for the Committee to review and consider. These recommendations were categorized into groups by stakeholder – recommendations for NQF, recommendations for measure developers and recommendations for other stakeholders (researchers, end-users, etc.). During the discussion of the final draft recommendations, the Committee members expressed strong support for most of the recommendations brought forth; however, the idea of stakeholder responsibility was mentioned as it relates to implementation of recommendations. The Committee highlighted the importance of shared accountability, resources and identifying the right stakeholders who can help with further reach and penetration of key recommendations in a practical way. One committee member suggested offering incentives to get stakeholders to be more involved in taking accountability for these recommendations and implementing them in practice.

Dr. Alberti also presented a brief summary of the key recommendations for the Committee's feedback. Specifically, these suggestions included (1) Eliminating health care inequities should be a funding priority, (2) Treating social factors the same as clinical factors, (3) Develop universal, standardized, automated screening practices and methods for social risk factors, (4) Ensure analysis of social risk focuses includes both statistical analysis and ranking/penalty impacts, (5) Transparency in reporting, which should include stratification to highlight (not mask) inequities, and (6) Connect directly to evidence-based interventions, when available.

The Committee responded well to these initial suggestions from Dr. Alberti and discussed further revisions. One member mentioned the risk of concealing a certain demographic of individuals if there is no data. The specific example referenced were persons with disabilities. Within hospitals and health clinics capturing and tracking disability data is inconsistent. Various approaches to including social risk factors in analyses by measure developers were discussed. For some measure developers, inclusion of disparities and stratification efforts are an afterthought rather than an initial step for inclusion. OR if the data is not available, then it can be difficult for researchers to identify disparities and social determinants of health. One Committee member offered a reason that measure developers are not collecting the data is because the developers do not have a purpose for it; without guidance from NQF or others that health disparities data is important and needs to be measured, researchers will not need or be able to get this data. The Committee agreed that identifying a basic comprehensive data set is very useful, which allows scientists and researchers to look more in depth at what data points might be missing. The idea of having external stakeholders (as opposed to clinicians) assist with the data collection and validation was also noted to reduce potential burden.

Dr. LaWanda Burwell, CMS COR, inquired about how risk adjustment contributes to the reduction of disparities. In response to Dr. Burwell's question, a committee member mentioned the recent report by the Office of Assistant Secretary for Planning and Evaluation (ASPE), which highlighted risk adjustment for specific variables like payment and asked whether it would be in the best interest of NQF and the Disparities Standing Committee to try and specialize on certain factors. The idea of tying risk adjustment to payment was not widely accepted by all committee members. As one member cited that sometimes the analytical results can go in opposite directions depending on which variables such as race/ethnicity or similar variables are included. It was added by another committee member that some researchers do not adjust for race since race is not a risk factor, and it might be more beneficial to measure social risk factors and factors that can contribute to the experiences of racism. To address the point about how risk adjustment can contribute to the reduction of health disparities, Committee members responded that if hospitals that treat more patients with social risk variables was *not* accounted for, then the risk of moving resources from the most vulnerable hospitals and their patients could be higher. A suggestion was made to develop clear guidelines to reduce penalties for hospitals related to the use of social risk factors in measurement and accountability programs. In addition, another member noted that risk adjustment should not be the only measurement used to ensure safety net providers are not penalized, rather a fair assessment of quality measurement would include other resources or strategies.

NQF staff shared with the Committee that feedback across all recommendations will be captured and included in the final report.

Public Comment

As Ms. Williams opened for Member and Public Comment, an experienced NQF patient advocate made note that language can also be a social risk factor that should be considered since patients with English as a second language can be correlated with worse health outcomes. Furthermore, transportation, food insecurity, homelessness, and other factors are going to be even more important to measure, especially as the COVID pandemic continues to affect the general population. NQF reinforced that the patient voice is an important addition to the committees, especially when it comes to the social risk trial and the risk adjustment project.

There were no additional public or member comments.

Next Steps

Ms. Williams summarized next steps to close out the call. NQF will share the first draft of the draft recommendation report with CMS on January 15, 2021. The public commenting period for the draft recommendation report will be from February 26 – March 29, 2021, and the final web meeting will be held on April 14, 2021 to address comments received.