Summary of Technical Expert Panel (TEP) Meeting # 1
November 16, 2021:
Health Equity Quality Measurement
Hospital Commitment to Health Equity Measure

February 2022

Prepared by:
Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (CORE)

This material was prepared by CORE under contract to the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

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The materials within this document do not represent final measure specifications for the Hospital Commitment to Health Equity structural measure.

Background

The Centers for Medicare & Medicaid Services (CMS) has contracted with Yale New Haven Health Services Corporation - Center for Outcomes Research and Evaluation (CORE) to develop measurement tools to assess the level of disparity in outcomes and commitment to health equity at hospitals. Under this contract, CORE is developing a proposed structural measure titled *Hospital Commitment to Health Equity*. The contract name is Development, Reevaluation, and Implementation of Outcome/Efficiency Measures for Hospital and Eligible Clinicians, Option Period 2. The contract number is HHSM-75FCMC18D0042, Task Order Number HHSM-75FCMC19F0001.

CORE is obtaining expert and stakeholder input on the proposed measure. The CORE measure development team is comprised of experts in quality outcomes measurement and measure development. CORE also convened a technical expert panel (TEP) of clinicians, patient advocates, and other stakeholders to provide input on the measure. Collectively, the TEP members brought expertise in consumer/patient/family caregiver perspectives, clinical content, performance measurement, and healthcare disparities.

This report summarizes the feedback and recommendations received from the TEP during the first meeting, which focused on the proposed measure concept and preliminary measure specifications.

Measure Development Team

The CORE Measure Development Team provides a range of expertise in outcome measure development, health services research, clinical medicine, statistics, and measurement methodology. See Appendix A for the full list of members for the CORE Measure Development Team.

The TEP

The TEP was originally convened in 2018. For this TEP, in alignment with the CMS Measures Management System (MMS), CORE held a 30-day public call for nominations and convened a TEP for the development and reevaluation of methodologies that illuminate disparities in hospital outcome measures using patient social risk factors. CORE solicited potential TEP members via a posting on CMS's website and emails to individuals and organizations recommended by the measure development team and stakeholder groups and email blasts sent to CMS physician and hospital email listservs.

The TEP was reconvened in Spring 2021 to provide additional input on initiatives related to health equity in CMS programs. Of the original 12 TEP members, nine agreed to reconvene. Two of the three members who asked not to participate were patient and family representatives, and to fill this perspective two new patient and family representatives were

recruited. The final TEP is composed of nine members, listed in Table 1. See Appendix E for a list of the original twelve TEP members.

The role of the TEP is to provide feedback and recommendations on key methodological and clinical decisions. The appointment term for the TEP is from November 2021 to March 2022.

Specific Responsibilities of the TEP Members

- Complete and submit all nomination materials, including the TEP Nomination Form, statement of interest, and curriculum vitae
- Review background materials provided by CORE prior to each TEP meeting
- Attend and actively participate in TEP conference calls
- Provide input on key clinical, methodological, and other decisions
- Provide feedback on key policy or other non-technical issues
- Review the TEP summary report prior to public release
- Be available to discuss recommendations and perspectives following TEP meetings and public release of the TEP Summary Report to CMS

Table 1. TEP Member Name, Affiliation, and Location

Name	Title, Organization	Location
Philip Alberti, PhD	Founding Director, Center for Health Justice at Association of American Medical Colleges (AAMC); Senior Director, Health Equity Research and Policy, AAMC	Washington, DC
David Baker, MD, MPH, FACP	Executive Vice President, The Joint Commission	Oakbrook Terrace, Illinois
Ashley Crowley	Person and Family Engagement (PFE) Expert	Quinter, KS
Tamarah Duperval-Brownlee, MD, MPH, MBA, FAAFP	Chief Health Officer, Accenture	St. Louis, MO
Jonathan Gleason, MD	Executive Vice President, Chief Clinical Officer, Prisma Health	Greenville, South Carolina
D'Anna Holmes	Person and Family Engagement (PFE) Expert	Chicago, IL

Name	Title, Organization	Location
Ninez Ponce, PhD, MPP	Director, University of California, Los Angeles (UCLA) Center for Health Policy Research; Principal Investigator, California Health Interview Survey; Professor, Department of Health Policy and Management, Fielding School of Public Health at UCLA	Los Angeles, CA
Aswita Tan-McGrory, MBA, MSPH	Director of the Disparities Solutions Center, Massachusetts General Hospital; Administrative Director, Mongan Institute	Boston, MA
Jorge Villegas, PhD, MBA	Person and Family Engagement (PFE) Expert; Associate Dean and Professor, College of Business and Management at University of Illinois at Springfield	Springfield, Illinois

TEP Meetings

CORE held a TEP meeting in November 2021, in which the proposed *Hospital Commitment to Health Equity* Structural Measure was presented. This summary report contains a summary of this TEP meeting. The presentation of other health equity measures or initiatives will be presented in separate, subsequent summary report(s), as those meetings are scheduled.

TEP meetings follow a structured format consisting of the presentation of key issues identified during measure development, as well as CORE's proposed approaches to addressing the issues, followed by an open discussion of these issues by the TEP members.

TEP Meeting Overview

Prior to the TEP meeting, TEP members received detailed meeting materials outlining the measure background, rationale, measure description and proposed approach for the *Hospital Commitment to Health Equity* measure.

During the TEP meeting, CORE solicited feedback from the TEP on the measure concept, measure domains and supporting evidence. CORE educated the TEP on the background and approach to developing the *Hospital Commitment to Health Equity* measure. Information was provided on how CMS has used structural measures in the past to encourage the use of tools, strategies and best practices associated with better care and outcomes. Additionally, the TEP

was invited to provide general input on hospital structures or capacities that may reduce healthcare disparities.

Following the meeting, TEP members unable to join the TEP teleconference were given the meeting recording and detailed meeting minutes.

The following bullets represent a high-level summary of what was presented and discussed during the TEP meeting. For further details, please see Appendix C.

Measure Background and Approach

- CORE solicited feedback from the TEP on the proposed *Hospital Commitment to Health Equity* structural measure.
- Dr. Bernheim presented information on the measure background, measure rationale and the discussion goals and then presented each of the measure domains and sub-domains and supporting evidence. For a description of the measure domains, please see Appendix D.
- Mr. Goutos facilitated three round-robin discussions, including an initial discussion to elicit TEP member's feedback on the structures and capacities that hospitals need to have in place to reduce healthcare disparities.

Summary of TEP Input

- Throughout discussion, several TEP members focused on the specifics of the measure's language and discussed how specific or how broad the attestation language should be to ensure hospitals take meaningful action and do not avoid the intent of the measure; that is, where hospitals just "check the box."
- TEP members provided feedback in response to the initial discussion question regarding their overall perspective on capacities and structures needed to decrease health care disparities as summarized below.
- TEP members mentioned the importance of training, education, and transparency as key components of what hospitals need to reduce healthcare disparities.
- Several TEP members also mentioned the importance of engagement with patients and the surrounding community.
- TEP members mentioned the importance of middle-management and C-suite buy-in, accountability of hospital leadership, and stressed the importance of meaningful patient and community engagement in development of the hospital strategic plan.
- Several TEP members commented on use of the terms, "disparities" and "equity," noting the broadness and complexities of these concepts. Dr. Bernheim acknowledged the importance of TEP members' comments that the goals focus on capacities that help decrease disparities in health.
- TEP members provided a range of feedback on Domain 1: Equity is a Strategic Priority & Domain 2: Data Collection.

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- TEP members mentioned the importance of collecting valid and reliable demographic and social determinants of health (SDOH) data and of having a process to ensure that the data is accurate including the need for training in data collection.
- One TEP member provided an example of a successful hospital data collection and intervention effort, but also noted the potential for unintended consequences if data collection is not done well.
- One TEP member stated that the steps outlined in the measure are not enough, stressing that integration of equity into the hospital infrastructure is needed to achieve equity goals.
- TEP members provide a variety of feedback on Domain 3: Data Analysis, Domain 4: Quality Improvement & Domain 5: Culture of Equity.
- Several TEP members commented on the operationalization of the data analyses domain, questioning how stratified analysis would be implemented and suggesting that the target is right but stratifying by SDOH is a reach.
- Another TEP member commented that there is evidence to support all 3 of these domains, but not as currently operationalized.
- Several TEP members expressed concern about the disconnect between the concept "Culture of Equity" in the name of Domain 5 and the focus on "Leadership Engagement" in the associated attestation questions.
- One TEP member concluded that, although flaws have been pointed out, this measure is a good step forward since there is not a lot of guidance in this realm.
- Dr. Bernheim thanked TEP members and encouraged all to email CORE with any additional feedback.
- Mr. Goutos concluded the meeting noting next steps.

Next Steps

Ongoing Measure Development

CORE will continue to encourage further feedback and questions from TEP members via email. CORE will present this measure at the December Measure Applications Partnership (MAP) meeting which will inform next steps. Additionally, CORE will continue to engage stakeholders to solicit feedback on this and other equity/disparities measurement projects.

Conclusion

The TEP provided valuable feedback on the proposed measure. Yale CORE made some edits to the measure specifications on the basis of this feedback. CORE will continue to engage with the TEP as the measure moves through measure endorsement and implementation planning.

Appendix A. CORE Measure Development Team

Table 2. Center for Outcomes Research and Evaluation (CORE) Team Members

Name	Role
Lori Wallace, PhD, MPH	Health Services Researcher
Jeph Herrin, PhD	Health Services Researcher
Alon Peltz, MD, MBA, MHS	Clinical Investigator
Liana Fixell, MPH	Project Manager
Demetri Goutos, MBA	Project Coordinator
Genne Murphy, MFA	Project Coordinator
Lear Burton, BS	Research Support
Eve Rothenberg, BA	Research Support
Shani Legore, BA	Person and Family Engagement Communication Specialist
Susannah Bernheim, MD, MHS	Project Director
Zhenqiu Lin, PhD	Director, Data Management and Analytics
Lisa Suter, MD	Contract Director, Quality Measurement Program

Appendix B. TEP Call Schedule

A list of TEP meetings scheduled during the contract Option Period 2.

TEP Meeting #1

Tuesday, November 16, 2021 – 4:00-6:00PM EST (Zoom Teleconference)

TEP Meeting #2

March 2022, TBA (tentative)

Appendix C. Detailed Summary of TEP Meeting #1

Health Equity Quality Measurement Technical Expert Panel (TEP) Meeting #1 Minutes: Hospital Commitment to Health Equity

Tuesday, November 16 4:00-6:00 PM ET

Participants:

Technical Expert Panel (TEP) Members: Philip Alberti, PhD; David Baker, MD, MPH, FACP; Ashley Crowley; Jonathan Gleason, MD; D'Anna Holmes, Aswita Tan-McGrory, MBA, MSPH; Jorge Villegas, PhD, MBA

Yale New Have Health Services Corporation – Center for Outcomes Research and Evaluation (CORE):
Susannah Bernheim, MD, MHS; Lear Burton, BS; Liana Fixell, MPH; Demetri Goutos, MBA; Sapha Hassan, MPH; Shani Legore, BA; Genne Murphy, MFA; Alon Peltz, MD, MBA, MHS; Eve Rothenberg, BA; Lori Wallace, PhD, MPH

The Center for Medicare & Medicaid Services (CMS): Reid Kiser, MS

Executive Summary

The Technical Expert Panel (TEP) met on November 16th, 2021, for a two-hour Zoom meeting. Discussion topics included: Using structural measures to reduce health disparities; review of the proposed structural measure *Hospital Commitment to Health Equity* and its components.

CORE and TEP Action Items:

- In the coming weeks, CORE will circulate the meeting minutes and Summary Report for TEP feedback.
- CORE will discuss TEP input and consider updates to measure specification.

Welcome

- Demetri Goutos, MBA welcomed all participants and provided information on confidentiality reminders, funding source, purpose, member responsibilities and meeting norms.
- Participants introduced themselves and stated any conflicts of interest.

Review and Approval of the TEP Charter

- Mr. Goutos reviewed the TEP Charter; TEP members noted no concerns and the TEP Charter was unanimously approved.

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Definitions

- Susannah Bernheim, MD, MHS noted differing definitions of "equity" (systematic, fair, and impartial treatment of all individuals) and "health equity" (everyone has a fair opportunity to be as healthy as possible without obstacles in the realm of healthcare providers), acknowledging the importance of improving healthcare equity, by reducing healthcare disparities, in achieving larger goal of equity.

Initial Discussion Question

- Dr. Bernheim stated the purpose of the meeting is to review the proposed *Hospital Commitment to Health Equity* structural measure and gather TEP feedback on the measure domains and supporting evidence, starting with an initial discussion question moderated by Mr. Goutos:
- "What structures or capacities do hospitals need in place to reduce healthcare disparities?"
- A TEP member suggested leadership and middle-management buy-in, good data collection efforts, and the ability to monitor and report on data are important factors. They highlighted the importance of funding, training, and education to support these efforts, as well as a commitment to transparency within the hospital community, to patients, and the larger community served. They suggested collaboration with community-based partners is important.
- A TEP member emphasized the importance of patient and community engagement, infrastructure, investment. They suggested tying C-suite income to health equity goals is effective, as is an investment in community health workers and navigators to create formal linkages between patients, families, and communities. The TEP member noted it is key to consider if an institution serves all patients equally regardless of their ability to pay or insurance status. They explained the importance of thinking about data across the continuum of care, with the goal of connecting healthcare and patients to local social services and community-based assets, and the need for providers to not only refer, but then follow-up and make multi-sector data commitments.
- A TEP member suggested hospitals need to understand social determinants of health (SDOH) within the community and act on them and highlighted the importance of community behaviors and SDOH data while examining the patient process holistically.
- A TEP member suggested it is important to ask what we are trying to solve in health disparities and to not shy away from addressing structural racism in these efforts. They discussed the importance of general bias training, and that while C-suite at-risk income may help, it would be beneficial to have a reporting structure that addresses racism, bias, and any disconnect between senior leadership and what is happening at the bedside of patients. The TEP member described it would be useful for patients of color to see more diverse senior leadership at health facilities.

- A TEP member expressed that a health facility can maintain wellness and reduce health disparities by forming a deep relationship with the community it serves. They stated this is not often allowable or funded by a fee-for-service arrangement but served by a value-based care arrangement or Accountable Care Organizations (ACO's). This member also suggested patient and family advisory councils are positive examples of strong community partnerships. The TEP member highlighted the importance of both quantitative and qualitative measurement in terms of how communities are measured, and how demographic data is captured, as well as the time and investment required to do so effectively. They noted the importance of engaging with social science experts and ethicists in this work. The TEP member emphasized prioritization, expressed it is important for hospitals to include a health disparities process or outcome measure on their board-endorsed quality plan and suggested CMS contemplate having one of the measures within the quality plan relate to health disparity (such as patient reported inclusion). To this end, the TEP member noted the importance of creating patient-reported measures of bias and inclusion.
- A TEP member expressed key structural components would include having a leader that reports up to the C-Suite or board as well as a multidisciplinary team that surrounds the community. They discussed the ideas of organizational assessment to collect the needs of the patients in addition to SDOH analyses and stressed it is key to examine internal data for disparities, specifically patient experience of care and maltreatment. Additionally, they explained how a health equity action plan is needed to prioritize different efforts and related resources for implementation and needs a similar structure as a quality and safety plan.
- A TEP member expressed healthcare facilities must look at a variety of perspectives and patient experiences to address disparities. They noted that "disparities" is a large word that encompasses many complex factors, including access to transportation, insurance, and resources, and spoke to the need for healthcare facilities to be respectful of varied religious and cultural backgrounds. The TEP member emphasized it is important to ask if patients are being heard, and if and why patients may be mistrustful of their providers or fear sharing health information. They stated that healthcare facilities may initiate community partnerships and structures that look great to the public eye but are not effective.
- Dr. Bernheim agreed with a TEP member's point that all hospitals are different and explained that part of the meeting's goal is to discuss whether the proposed structural measure works across different types of hospitals.
- A TEP member asked whether CMS is interested in organizational equity, health equity or healthcare equity, as their feedback may change depending on which equity goal is being targeted (i.e., within organizations, within the patient populations or within the communities).

- Dr. Bernheim acknowledged the importance of this question and asked the group to consider the best starting point for hospitals to achieve an end goal that targets all these outlined types of equity.

Measure Background and Rationale

- Dr. Bernheim introduced the proposed *Hospital Commitment to Health Equity* measure by outlining the FY 2022 inpatient prospective payment system (IPPS) Proposed Rule Request and stated key elements of the measure are adapted from principles outlined in the CMS Office of Minority Health (OMH) Health Disparities Guide.
- Dr. Bernheim shared key takeaways from the public comment, including:
- The measure should be actionable for providers,
- There should be engagement with stakeholders,
- There should be confidential reporting until measures can be validated, and,
- There should be a full review of existing programs and guidance.
- Dr. Bernheim noted that the proposed measure was submitted to the Measures Under Consideration list in May 2021.
- A TEP member stated that perceptions of equity may vary across an organization and shared a concern this could be a "check box" measure. They cited, as an example, that inviting a person of color onto a hospital facility board may be viewed by leadership as a positive equity measure, but this does not alone guarantee equity.
- Dr. Bernheim agreed this is a critical question and acknowledged that hospitals may have different needs, and that these structures may not translate to equity for everyone. She asked the TEP to consider if there are fundamental things to ask of hospitals and/or a valuable starting place for equity measures, across the board.
- Dr. Bernheim noted strong, consistent leadership can be instrumental for setting specific, measurable, and attainable goals to advance equity. She explained that structural measures are those that assess the presence or absence of capacities, systems, and structures of care. Dr. Bernheim stated that structural measures do not directly assess care delivery or outcomes but that they support and encourage the use of tools and strategies that are associated with better care and outcomes. Dr. Bernheim also expressed how CMS has used structural measures in the past to encourage participation in registries, quality improvement activities, or to advance the use of electronic health records. Dr. Bernheim emphasized that the *Hospital Commitment to Health Equity* measure is not an outcomes measure, but rather a set of questions to which hospitals will respond.
- A TEP member raised the point that translation services and telemedicine are very important.
- A TEP member confirmed the above definition of attestation measures and explained they do not fully support these (ex: in the context of maternal morbidity measures) but

acknowledged attestation measures are an important intermediary step. They noted when examining the validity of a structural measure, it is important to look at the specific components of the attestation request.

- A TEP member noted that when looking at communities of color and maternal morbidity the issue is more of a SDOH/bias issue, which is still an important outcome measure. They suggested that structural measures give providers a "check box" mentality.
- Dr. Bernheim expressed that the maternal morbidity measure is a good example of how structural measures are used. CMS put forward an initial measure so that hospitals can engage in quality improvement; furthermore, CMS is partnering with the Joint Commission to develop an outcome measure that is going to examine outcomes in that realm.

Measure Description & TEP Discussion

- Dr. Bernheim outlined the proposed measure which includes five attestation-based questions, each representing a separate domain of commitment.
- A hospital would receive a point for each domain where it attests "Yes" to each of the corresponding Yes/No statements (for a total of 0-5 points).
- For domains with multiple elements, attestation of all elements would be required to qualify for the measure numerator.

Domain 1: Equity is a Strategic Priority

- Dr. Bernheim presented Domain 1: "Equity as a Strategic Priority" by reading the proposed attestation question and sub-questions.
- Dr. Bernheim expressed the rationale and supporting evidence for this domain by stating that equity as a strategic priority is an emerging field as demonstrated actions of specific health systems. Additionally, there is broad conceptual support for addressing health disparities from many influential organizations providing the example of the Institute for Healthcare Improvement, American Hospital Association, Association of American Medical Colleges (AAMC).

Domain 2: Data Collection

- Dr. Bernheim presented Domain 2: "Data Collection" by reading the proposed attestation question and sub-questions.
- Dr. Bernheim emphasized that standardized data collection is a necessary component of measuring, tracking, and comparing performance on health equity across providers and she also highlighted foundation support. The slides demonstrated examples of recent efforts. She also explained that if the goal is to track disparities, then tracking the data is a key component.

Discussion of Domains 1 and 2

- Dr. Bernheim asked the group if they have experience or evidence that supports the benefit of Domains 1 and 2. She also inquired whether the group had any concerns regarding unintended consequences of measurement.
- A TEP member responded by stating that rural hospitals are going out of business causing rural America to lose access to healthcare at high rates and therefore useful to allow community health needs assessment to also meet structural requirements. The TEP member emphasized that collecting valid and reliable demographic and SDOH data requires training; if this data collection is mandated quantitatively, but there are not resources for individuals to do this well, then the data can be wrong and can lead action in the wrong direction promoting health disparities. The TEP member noted the proposed measure mentions demographic data (speculating only race and ethnicity data) which seems like a narrow view of health disparities and equity.
- A TEP member positively commended the domains and emphasized that how they are operationalized is key. They suggested CMS would benefit from further specifications in the first domain, ideally focusing on one bucket, such as healthcare equity, that should serve as the basis for how hospitals and health systems should be rewarded. The TEP member asked if hospitals and health systems should receive credit for things they are already required to do per current regulations or requirements. They questioned if the goal of Domain 2 is to capture social determinants of health for the communities or patient related social needs, and that it would be beneficial for CMS to align with CMMI for consistency. Lastly, in terms of data collection, the TEP member speculated whether the goal is to encourage the formal diagnosis with the Z codes, which adds research capacity and policy capacity, or if the goal is the screening.
- A TEP member highlighted that it is important to ask how thorough and involved the data collection is, who is collecting it, and in what setting it is being collected. Additionally, they expressed that the language used for data collection is important and the two domains presented are still very broad.
- A TEP member shared they do not believe Domain 1 requires much supporting evidence as there are not significant or rigorous studies on these issues. They raised the point that if you do not make something a strategic priority, nothing happens, while there are examples of organizations that set equity as a strategic priority which galvanizes the community to move it forward. The TEP member stated that data analysis to understand disparities and to target interventions requires accurate collection of demographic and SDOH data and cited an example of a hospital in Los Angeles that started collecting language data when scheduling outpatient appointments, using interpreters. They stated the largest unintended consequence is when demographic data collection is not done well, without sensitivity or training, as patients may view it as profiling or bias against them.

- A TEP member echoed previous feedback, questioning the implementation process and potential for this to be a "check box" measure and agreed with the difficulties in collecting data from certain patient populations. They supported meaningful connections between senior leadership and communities and asked if there can be more rigor around how health systems are asked to set up goals related to community partnership. Additionally, the TEP member highlighted that the measure could place a burden on community organizations that may already be under resourced and questioned if hospitals and health systems should then provide funding to their community partners.
- A TEP member stated that outlining steps to achieve equity goals is not enough, and the goal should be integration of equity into the infrastructure. They expressed that accountability should be added as a bucket to Domain 1, providing the example of compensational consequence if the goals are not met. The TEP member noted that the strategic plan should include a method of accountability such as a reporting structure regarding microaggressions or racism. Regarding the data collection domain, they suggested adding in a point about whether hospitals can validate that the data is accurate and reliable.
- Dr. Bernheim thanked TEP members for their comments and provided an overview of the TEP feedback:
- The consensus for Domain 1 is that it is necessary – but it is a challenge to ensure the questions capture whether hospitals are engaging in certain equity efforts. Dr. Bernheim noted concern was expressed that hospitals may already report aspects of this work for the community needs assessment. She summarized the varied feedback on how to integrate community into strategic planning and cautions about increased burden.
- For Domain 2, Dr. Bernheim commented that the group highlighted the tension between what data collection should be mandated in this measure and that there are pros and cons to how specifically expectations are delineated in the measure.

Domain 3: Data Analysis

- Dr. Bernheim presented Domain 3: "Data Analysis" by reading the proposed attestation question and sub-questions.
- Dr. Bernheim expressed that the rationale for this domain is supported by a significant amount of agency, organization, and foundation support. The slides also demonstrated examples of research showing a link between stratifying key performance indicators by demographic factors and a reduction in disparities.

Domain 4: Quality Improvement

- Dr. Bernheim presented Domain 4: "Quality Improvement" by reading the proposed attestation question and sub-questions.

- Dr. Bernheim explained that rationale for Domain #4 is based on research evidence and conceptual support. The slides demonstrated that conceptual support for this domain is also provided by a variety of organizations and institutions (ex: IHI, Racial Equity Institute, and FSG) and findings suggest the need for careful consideration, and continued monitoring, of health disparities before and during implementation of equity-focused QI initiatives.

Domain 5: Culture of Equity

- Dr. Bernheim presented Domain 5: "Culture of Equity" by reading the proposed attestation question and sub-questions.
- Dr. Bernheim provided rationale and supporting evidence for this domain by explaining that studies have shown that hospital leadership buy-in to patient safety and quality improvement initiatives is associated with improvements in each respective domain. Additionally, the slides noted that a recent qualitative study (Doherty et al. 2021) supports the assumption that hospital leadership buy-in to initiatives focused on reducing health disparities is associated with positive improvement. Finally, the presentation slides demonstrate that AHRQ, JCAHO, and the CMS Office of Minority Health also recommend or provide support for the use of the approaches included in this attestation domain for addressing health disparities.

Discussion of Domains 3,4, 5:

- A TEP member emphasized that exploring the issue of a "Culture of Equity" is not the same as "Leadership Engagement." They suggested Domain 5 can be listed as leadership accountability to be more closely tied to the underlying questions. Regarding stratified measures of social determinants of health within the data analysis domain, the TEP member noted that many hospitals likely are not doing this and if they are, they are likely not using Z codes. They questioned how hospitals would analyze their data if they do not have it in a structured format. They commented that the data analysis domain is the right target but including SDOH seems a bit too far for an attestation measure.
- A TEP member commented that for Domain 3, stratifying by SDOH is a reach and even if hospitals are collecting this information, they likely are not able to stratify their quality metrics by SDOH because they may not be collecting this information for all patients (ex: perhaps only community health patients). The TEP member noted the focus on demographic variables and stated there has been a lot of effort in that area, yet no substantial reporting or outcomes on racial and ethnic disparities at the hospital and health center level. The TEP member liked the Domain 5 term, "Culture of Equity," but indicated that the using "Leadership Engagement" does not reflect accountability. They highlighted there is an intense focus on hospital leaders, but when integrational and organizational transformation is needed, middle-management buy-in is essential and often overlooked. In terms of involvement in QI initiatives (Domain 4), the TEP member

commented this has the potential to be very "check box" in the sense that just because specific programs exist, this does not mean that all patients benefit.

- A TEP member shared that for Domain 5, it is important to ask how diverse a specific hospital's workforce and board is, and to identify if microaggressions and racism occur within the workforce and among the patient population. They supported other feedback about middle-manager buy-in. For Domain 4, the TEP member discussed it is important to consider how "participation" is defined for QI initiatives, noting the difference between holding a booth at a local health event versus sustained partnerships with community organizations. They echoed concerns about the measures encouraging a "checkbox" mentality.
- A TEP member commented that there is evidence to support all 3 of these domains but it is not operationalized. Regarding Domain 3, analysis and stratification are important, but who is the information being reported to? The TEP member provided the example of Massachusetts General Hospital (MGH) which published a healthcare disparity report internally and posted it externally, demonstrating an important level of transparency. They acknowledged the unintended consequence of intersectionality because stratifying down to one level does not capture the diversity within our diversity. The TEP member noted that measuring health gaps is not the same as measuring health opportunity. They expressed that the QI and analysis domains seem closely tied to healthcare equity and were surprised there was no mention of patient engagement in developing QI and analysis. T. Regarding Domain 5, the TEP member commented that developing a measure about "culture of equity" is very general and can mean other types of equity outside of healthcare equity, concluding that if the goal is to focus on leadership engagement, then the "checkboxes" are too easy and there should be at-risk compensation or incentive structures to measure leadership engagement.
- A TEP member commented that Domain 3 may be particularly challenging for rural hospitals to do in a rigorous way. They expressed that if a hospital and its staff is not equipped with data skills or resources to think deeply about equity implications, there could be a risk of promoting bias within the provider group and ultimately promoting health disparities. The TEP member noted the concern and potential unintended consequence of under resourced hospitals examining race and ethnicity, applying it to outcome measures and presenting this to their organization without first establishing a relationship with the community or calling in social science experts to help organizations truly understand the extent of this data. They agreed with previous comments on the lack of SDOH data in healthcare and the challenges of acquiring that data for small hospitals. The TEP member expressed concern over how many questions patients should have to answer to gain access to health services and the general availability and management of the data. Regarding leadership engagement, they stated that the board can significantly determine the direction of an organization and most boards do take

endorsements seriously, concluding that putting equity-focused plans in front of board and trustees is important because if not, it is difficult for these to be successful.

- A TEP member expressed that accountability and accessibility are very important. The TEP member shared that discussion of disparities is not part of the common dialogue in some communities or is shut down due to limited exposure. The TEP member commented it is necessary to take a step back and ask why the "checkboxes" exist since many doctors do not acknowledge the health disparities in the first place. They questioned where there could be a starting point to explore these conversations in a rural community.
- Mr. Goutos and Dr. Bernheim opened the floor for the TEP to provide any final comments. Dr. Bernheim acknowledged feedback about adjusting the language in the domains to hold hospitals more accountable and that domain 5 may be incorrectly labeled.
- A TEP member asked if, as a condition of participation, there is precedent for requiring strategic plans for things other than minimizing health disparities.
- Dr. Bernheim clarified that CORE is not proposing something that would be a condition of participation. She explained that CMS has not indicated use of the measure yet.
- A TEP member responded that there are analogies such as emergency management and infection prevention and control. They commented that the goal should be to push organizations to establish a structure they can build upon as an effective starting place. The TEP member also emphasized the importance of engaging the middle managers to ensure everyone is on board.
- One member commented that many plans exist, but they are not labeled as strategic plans. Another member responded that those plans are not necessarily strategic according to purists; they are more so tactics. The strategic component is when something is established as a priority.
- A TEP member suggested that at the next TEP, CORE should develop a process for moderating which hands are raised to facilitate the discussion more effectively and ensure each member has an equitable amount of time to share feedback.
- The TEP member commented that although flaws have been pointed out with this structural measure, this is a good step forward since there is not a lot of current guidance in this realm.
- Dr. Bernheim noted that overall support for this direction has been beneficial in addition to the feedback about how the measure can be improved. Dr. Bernheim thanked TEP members and encouraged all to email CORE the with any additional feedback.

Concluding Remarks and Next Steps

- Mr. Goutos explained that the TEP discussion will be captured in minutes, which will be circulated to the TEP to provide feedback on followed by a Summary Report.

- Mr. Goutos noted that the next step for CORE will be a presentation at the December Measure Applications Partnership (MAP) meeting which will inform next steps.
- Mr. Goutos concluded by expressing that the CORE team hopes to convene this TEP again in late January or February 2022, to discuss ongoing work on this and other equity/disparities measurement projects.
- Lastly, Mr. Goutos thanked TEP members for their valuable feedback and for making time for this meeting on short notice. He encouraged TEP members to reach out to the cmsdisparitymethods@yale.edu email address with any additional feedback or questions.

Appendix D. Description of Measure Domains

The proposed *Hospital Commitment to Health Equity* measure domain language includes five attestation-based questions, each representing a separate domain of commitment. As proposed, a hospital would receive a point for each domain where it attests "Yes" to each of the corresponding Y/N statements (for a total of 0-5 points). For domains with multiple elements, attestation of all elements would be required to qualify for the measure numerator.

Domain 1: Equity is a Strategic Priority

1. Hospital commitment to reducing disparities is strengthened when equity is a key organizational priority. Please attest that your strategic plan for achieving health equity includes the following elements. Select all that apply:
    a. Our hospital strategic plan identifies priority populations who currently experience health care disparities.
    b. Our hospital strategic plan identifies equity goals and discrete action steps to achieving these goals.
    c. Our hospital strategic plan outlines specific resources which have been dedicated to achieving our goals.
    d. Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.

Domain 2: Data Collection

2. Collecting valid and reliable demographic and SDOH data on patients served in a hospital is the first step to identifying and eliminating health disparities. Please attest that your hospital engages in the following activities. Select all that apply:
    a. Our hospital collects demographic and SDOH information on the majority of our patients.
    b. Our hospital has training for staff in culturally sensitive collection of demographic and SDOH information.
    c. Our hospital inputs demographic and SDOH information collected from patients into structured, interoperable, data elements using a certified EHR technology.

Domain 3: Data Analysis

3. Effective data analysis can provide insights into which factors that contribute to health disparities and how to respond. Please attest that your hospital engages in the following activities. Select all that apply:
    a. Our hospital stratifies key performance indicators by demographic variables to identify equity gaps.
    b. Our hospital stratifies key performance indicators by SDOH to identify equity gaps.

Domain 4: Quality Improvement

4. Health disparities are evidence that high quality care has not been delivered equally to all patients. Engagement in Quality Improvement activities can improve quality of care for all patients. Please attest to the following:
    a. Our hospital participates in local, regional, or national Quality Improvement activities focused on reducing health disparities.

Domain 5: Culture of Equity

5. Leaders and staff can improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. Please attest that your hospital engages in the following activities. Select all that apply:
    a. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity.
    b. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and social factors.

Appendix E. List of TEP Members and Information from Initial Convening in May 2018

Table 3. TEP Member Name, Affiliation, and Location

Name	Title, Organization	Location
Philip Alberti, PhD	Senior Director, Health Equity, Research, and Policy, Association of American Medical Colleges	Washington, DC
David Baker, MD, MPH, FACP	Executive Vice President, Healthcare Quality Evaluation, The Joint Commission	Illinois
Tamarah Duperval-Brownlee, MD, MPH, MBA, FAAFP	Vice President, Care Excellence, Ascension	Missouri
Lynda Flowers, JD, MSN, RN	Senior Strategic Policy Advisor, American Association of Retired Persons	Washington, DC
Jonathan Gleason, MD	Vice President, Clinical Advancement and Patient Safety, Carilion Clinic	Virginia
Shane McBride, MBA	Patient Advocate, Founder and CEO, Healthcare Strategy and Operations Consultant, Chiron Strategy Group, LLC	Massachusetts
Sarita Mohanty, MD, MPH, MBA	Vice President, Care Coordination for Medicaid and Vulnerable Populations, National Medicaid, Kaiser Permanente	California
Kristina Mycek, MS, CAS	Project Lead and Statistician, Consumer Reports	New York
Ninez Ponce, MPP, PhD	Associate Center Director, Center for Health Policy Research, University of California	California
Aswita Tan-McGrory, MBA, MSPH	Deputy Director, Disparities Solutions Center, Massachusetts General Hospital	Massachusetts
Jorge Villegas, PhD, MBA	Patient Advocate, Associate Professor of Business Administration, University of Illinois, College of Business and Management	Illinois
Kimberlydawn Wisdom, MD, MS	Senior Vice President, Community Health and Equity, Chief Diversity, Henry Ford Health System	Michigan