



August 17, 2017

National Quality Forum

2017 BOARD OF DIRECTORS

Executive Committee

Gail Mukaihata Hannemann
Chairperson

Walter Tsou, MD, MPH
Vice Chairperson & Secretary

Diane Paloma, MBA, PhD
Treasurer

Elizabeth M.S. Krause, ScM
At-large

Gayle Tang, MSN, RN
At-large

Kathy Ko Chin
President & CEO

Debbie I. Chang, MPH

Jacob Fitisemanu Jr., MPH

Mark Keam, JD

Oliver Kim, LL.M, JD

Minh Thanh Nguyen

Payal Shah, Esq

Lori Villarosa

Dianne Yamashiro-Omi

Headquarters:

One Kaiser Plaza
Suite 850
Oakland, CA 94612
Main 415-954-9988
Fax 510-419-0263
www.apiahf.org

Washington D.C. Office:

1629 K Street N.W.
Suite 400
Washington, D.C. 20006
Main 202-466-7772
Fax 202-466-6444

*National Advocates for
Asian American,
Native Hawaiian &
Pacific Islander Health*

Re: Comments on Draft Report "A Roadmap to Reduce Healthcare Disparities Through Measurement"

Submitted via qualityforum.org portal

To whom it may concern:

General Comments on the Report

The Asian & Pacific Islander American Health Forum (APIAHF) is the nation's leading health policy group working to advance the health and well-being of over 20 million Asian Americans, Native Hawaiians and Pacific Islanders (AAs and NHPs) across the U.S. and territories. As such, APIAHF works to improve access to and the quality of care for communities who are predominately immigrant, many of whom are limited English proficient, and may be new to the U.S. health care system or unfamiliar with private or public coverage. APIAHF appreciates the opportunity to review and comment on the draft report "A Roadmap to Reduce Healthcare Disparities Through Measurement," (Report).

Overall, we wish to express our strong support for and adoption of the Report and the National Quality Forum's (NQF) work to develop an integrated roadmap to identifying and eventually eliminating health and healthcare disparities. The Report contains an extensive framework for identifying performance measures that address social risk factors for chronic diseases as a way to eliminate disparities and achieve health equity. Such work is critical at a time of rapid change in the healthcare delivery system and underscores, as outlined in the Report, the need for integration and emphasis of achieving health equity as an explicit goal in the process. Having performance measures that are evidence-based, broad in their scope so as to address various social risk factors for chronic conditions that disproportionately impact racial and ethnic minorities and others who are limited English proficient and/or experience other barriers to good health and quality health care, is critical to monitoring, assessing, evaluating and eventually eliminating disparities. Performance measures are a critical lever in achieving health equity and APIAHF welcomes NQF's Report on the issue.

We agree with the four-part model as a way of recognizing the value and accountability that all sectors, including payers, policymakers, providers and patients have in eliminating disparities. The Report and emphasis on sector-specific analysis recognizes the unique roles, assets and obligations each have in eliminating disparities. In particular, we welcome the inclusion of policymakers as well as community organizations that serve diverse groups and can serve as aggregators of information and resources and trusted messengers.

Step #1 Prioritize Disparities Sensitive Measures

Overall, the Asian & Pacific Islander American Health Forum appreciates the intersectional framework the Committee took that is expansive and acknowledges disparities across race, ethnicity, health literacy, language and many other social factors that influence health. We agree that measurement burden is a valid concern and must be balanced against the obligation and necessity to have measures that identify and ultimately eliminate health and healthcare disparities. While there are valid and important considerations about patient privacy in the context of small populations, we encourage the Committee to consider adding that where such concerns may prevent the public reporting of data, that methodologies such as oversampling and multi-year pooling techniques be considered. Overall, we agree that even if such data cannot be reported publicly, that should not be an excuse for failing to collect and stratify data internally. This distinction is critical for small but growing populations, such as Asian Americans, Native Hawaiians and Pacific Islanders who face different disparities compared to other groups and experience different disparities within specific subgroups (e.g. Native Hawaiians compared to aggregated Asian Americans).

Step #2 Identify Evidence-Based Interventions to Reduce Disparities

Overall, the Asian & Pacific Islander American Health Forum agrees that reducing disparities requires multi-level and sectorial interventions that address both resources, knowledge and institutional systems. As discussed throughout the Report, we note the critical nature and voice that persons who are directly impacted (patients and their caregivers/families) must have at different levels in disparity reduction programs to ensure such programs are responsive to their needs and ultimately address the various factors that influence health. Further, we welcome the need for interventions that address both racial and ethnic disparities, but also the intersections with health literacy, language, disability, income, education, etc. as a recognition that patients are whole people who experience multiple factors that influence their health in different ways.

Step #3 Select and Use Health Equity Performance Measures

We at the Asian & Pacific Islander American Health Forum welcome the scanning of existing performance measures that can be used in quality improvement programs. Such measures aim to minimize measurement burden on covered entities, while leveraging existing measurement infrastructure. In addition, we appreciate the identification and consideration given to gaps in measures that must be developed. We encourage NQF to consider, as done with this Report, broad stakeholder input in the development of such measures to address these gaps. Similarly, we welcome the explicit emphasis and inclusion of community, educational and other entities, who while not traditionally part of the healthcare delivery system, play a role in achieving health equity and provide critical supports to patients.

We strongly support the finalization of four domains of health equity. In particular, we emphasize the “Collaborate with other organizations or entities that influence the health of individuals” and inclusion of measures that address the social determinants of health in concrete and actionable ways. One such area is the community and services linkage, which has the potential to improve quality for persons who are limited English proficient. As outlined in our “[Connecting Limited English Proficient Individuals to Healthcare Systems Report](#),” (available at www.apiahf.org), there is a recognition amongst various sectors of the need to include community-based organizations (CBOs) within the healthcare system, yet operational challenges to doing so.

CBOs and other trusted community partners play a vital role in supporting a person’s “whole health” as they relate to language access, faith, mental and social support, education, financial security, etc. As noted in the Report, it is critical that there be collaboration and linkage amongst health providers of different types and amongst those who are in non-health/non-clinical areas. Such non-health/non-clinical entities provide essential services that are often not reimbursed by many payers (public or private), including patient navigation at the onset of enrollment, selection of appropriate primary care provider, resolution of and filing of appeals and other benefits claims. In addition, CBOs, for example, help patients understand what services are covered by their plans, provide assistance with scheduling appointments and help them obtain prescription drugs. These services are often provided with little to no reimbursement or resources to the CBO and are relied upon by racial and ethnic minorities and those with limited literacy, health literacy and English proficiency.

Although more LEP individuals have coverage, language continues to present a significant barrier when accessing health care services. Spoken language differences between patient and provider, the lack of appropriate interpretation services, and inadequate translated materials for patients all contribute to communication barriers that adversely affect health outcomes and contribute to the existence of health disparities. Patients who are LEP are less likely to seek care, even when insured, and experience lower quality of care and more adverse health outcomes, such as longer hospital stays and a greater chance of hospital readmission for certain chronic conditions, compared to those who speak English well. Many of those who need interpretation services are not aware of their rights to receive language assistance at a hospital or clinic.

CBOs serving Asian American, Native Hawaiian and Pacific Islander (AA and NHPI) communities often focus on providing services to specific AA and NHPI ethnic subgroups that are most represented in the community. Others provide services for segments in a community, such as immigrants and refugees, that often have a large proportion of individuals who came to the U.S. from an Asian or Pacific Island nation. Many of these individuals are LEP, and therefore CBOs frequently have multilingual staff and volunteers who come from the community with the necessary cultural understand to competently provide in-language assistance to the individuals they serve.

CBOs can function as a hub for LEP individuals who want to access care, but who need culturally and linguistically appropriate assistance to navigate the health care system. Although CBO staff may not be certified community health workers (CHWs), they still provide culturally competent in-language enrollment assistance and assistance in helping people access care and navigate the health care system. CBOs can serve as important members of a care coordination system designed to improve health care access and quality for LEP individuals and receive compensation for services provided by staff, just as CHWs are compensated for helping individuals navigate the health care system. This compensation could come in the form of contracts between CBOs and hospitals, insurers, and provider networks in which CBO staff provide interpretation and health system navigation for LEP individuals. Health plans could contract with CBOs to help their LEP members find providers, describe services covered under their plan, make appointments with providers, and provide interpretation assistance during clinic visits.

With respect to the “Culture of Equity” subdomain, we support protecting access to care through critical public programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Similarly, with respect to “Equitable Access to Care,” we welcome the addition of language accessibility as a measurement and strongly agree with equity in access to care as being a core tenant in achieving health equity.

With respect to the “Structures of Equity” subdomain, we agree with the integrated nature of data, both in terms of collection, reporting and analysis and having the systems and infrastructure in place to support robust, timely and accurate data collection.

Overall, the equity measures provide concrete ways to operationalize a drive to improve health equity and should be leveraged so that payers have an incentive to integrate them into their quality improvement programs. These measures are critical to assessing progress and eventually, as the report notes, creating incentives for adoption.

Step #4 Incentivize the Reduction of Health Disparities and Achievement of Health Equity

The Asian & Pacific Islander American Health Forum agrees that data are the bedrock of all measures and ability to understand, access, monitor and eliminate disparities and that such data should be stratified to the greatest extent possible, using systems that create ease in operation as much as possible (e.g. social risk factors in electronic health records). We welcome the strong emphasis on the levels of stratification and levels from which data is collected: clinical (Claims or administrative; patient-reported data; community and systems level). Moreover, we underscore the Committee’s recommendation on accountability and transparency. Public reporting of measures and activities is relevant not only to hold systems and providers accountable, but also empowers patients by providing them with information to take an active role in quality improvement and their care. It is difficult to imagine patients being able to play active, empowered roles in quality improvement without access to data most useful for the patient and provided in a form and manner that is responsive to patients (e.g. health literacy and linguistic competency).

APIAHF underscores performance measures can be used to continuously identify disparities in health and healthcare, used to hold various stakeholders accountable (providers, payers, policymakers) and to create incentives to reduce disparities and provide assistance to providers who are striving to improve quality and have a patient population that experiences a multitude of risk factors.

As such, we recognize the importance of adjusting for social risk factors in payment programs and share concern about both the burden on clinicians who disproportionately serve those with more social risk factors, while at the same time not creating lower standards for improving health outcomes in disadvantaged populations. We agree that one method of doing so is to directly adjust payment for social risk factors, stratify data across social risk factor groups to provide transparency and link health equity measures to accreditation programs.

Lastly, we strongly endorse the recommendation to conduct policy simulations and demonstration projects to test how interventions can mitigate disparities. For example, community-based organizations (CBO) represent a trusted and reliable connection to patients who come from diverse backgrounds, including those who are limited English proficient. We agree that there is a need to conduct such demonstration projects to determine how to effectively integrate CBOs into the healthcare delivery system, how to create sustainable funding models and ensure partnerships with payers and providers.

Thank you for the opportunity to comment on this Report. If you have questions, please contact Amina Ferati, Senior Director of Government Relations & Policy at aferati@apiahf.org.

Sincerely,

Kathy Ko Chin
President & CEO
Asian & Pacific Islander American Health Forum