STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

HEALTH EQUITY AND QUALITY

COMMITTEE MEETING

ONLINE/TELECONFERENCE MEETING

HOSTED BY THE

DEPARTMENT OF MANAGED HEALTH CARE

SACRAMENTO, CALIFORNIA

WEDNESDAY, APRIL 20, 2022

1:00 P.M.

Reported by: John Cota

APPEARANCES

Voting Committee Members

Anna Lee Amarnath

Bill Barcellona

Dannie Ceseña

Diana Douglas

Lishaun Francis

Tiffany Huyenh-Cho

Edward Juhn

Richard Riggs

Bihu Sandhir

Kiran Savage-Sangwan

Rhonda Smith

Doreena Wong

Silvia Yee

Ex Officio Committee Members

Palav Babaria

Alice Huan-mei Chen

Stesha Hodges

Julia Logan

Robyn Strong

APPEARANCES

DMHC Attendees

Mary Watanabe, Director

Nathan Nau, Deputy Director, Office of Plan Monitoring

Chris Jaeger, Chief Medical Officer

Sara Durston, Senior Attorney

Shaini Rodrigo, Staff Services Analyst

Sellers Dorsey Attendees

Sarah Brooks, Project Director - Facilitator

Alex Kanemaru, Project Manager

Andy Baskin, Quality SME, MD

Ignatius Bau, Health Equity SME

Mari Cantwell, California Health Care SME

Meredith Wurden, Health Plan SME

Nancy Kohler, Quality SME

Janel Myers, Quality SME

Others Presenting/Commenting

Reverend Mac Shorty

Irma Muñoz
Mujeres de la Tierra

Allen Noriega
CBO Illumination Foundation

Kristen Tarrell, RN
Western Health Advantage

Rachel Harrington

National Committee for Quality Assurance (NCQA)

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1 PROCEEDINGS

2 1:03 p.m.

3 MS. BROOKS: Good afternoon, everyone, and welcome to the
4 third Department of Managed Health Care Health Equity and Quality Committee.
5 As you know my name is Sarah Brooks; I am a consultant with Sellers Dorsey, a
6 consulting firm which is supporting the DMHC effort here. We are excited to be a
7 part of this process.

8 AB 133, the budget bill from last year, charges this committee with
9 making recommendations to the DMHC specifically on health equity and quality
10 measures and benchmarks that should be utilized for oversight of managed care
11 plans overseen by the DMHC.

12 During last month's meeting, sorry, as discussed in previous
13 meetings, these recommendations will be made and put forth to the DMHC in the
14 form of a report. So we will be taking input here, putting it into a report and
15 bringing that report back to you all for comment and we will talk a little bit more
16 about that today.

17 And during last month's meeting we heard from our data quality
18 subject matter experts from NCQA, IHA and RAND. We will talk a little bit more
19 about that today and have an opportunity for some discussion and comments
20 and from our quality and health equity subject matter experts on guiding
21 principles for measure selection and focus areas.

22 Based on the outcomes and lessons learned from last meeting we
23 will spend more time in today's meeting talking. We recognize that last meeting
24 we had a lot of presentations, not a lot of time for discussion. We really want to
25 hear from you today, so just re-emphasizing that, that we will have lots of

1 opportunity for discussion and discussion will go on until we have come to a point
2 where we feel that we have exercised all the comments and we are at a place to
3 move forward from that subject area.
4 So with that, we have a very packed agenda today. I am going to
5 turn it over to my colleague Janel Myers who is going to go over a few
6 housekeeping items.
7 MS. MYERS: Thanks, Sarah. Hi, everyone. Just going over the
8 housekeeping very quickly. I just wanted to note some items for those joining in-
9 person today:
10 There is a sanitation station located in the back of the room where
11 you will find masks and hand sanitizer. Masks are strongly encouraged today.
12 The restrooms on this floor are locked. The bathroom matches are
13 on the table at the back of the room so please make sure to return them to the
14 table.
15 Please remember to silence your cell phones throughout this
16 meeting as well.
17 And for Committee Members there in-person, please do not join the
18 Zoom meeting with your computer audio. To ensure that you are heard online
19 and in the room please use the microphone in front of you and push the button
20 on your microphone to turn it on or off. The green light will indicate that it is on,
21 red will indicate that it is off. Please remember to turn off your microphone when
22 you have finished and please speak directly into the microphone and move it
23 closer to you if necessary to ensure that everyone can hear you.
24 Questions and comments will be taken after each agenda item, first
25 from the Committee Members and then from the public. For those who wish to

1 make a comment please remember to state your name and the organization you
2 are representing. If any Committee Member has a question please use the
3 Raise Hand feature. All questions and comments from the Committee Members
4 will be taken in the order in which the raised hands appear.
5 Public comment will be taken from individuals attending in-person
6 first. For making public comment at the podium in the front of the room please
7 be sure to leave your business card or write down your name and title and leave
8 it on the podium so that our transcriber can accurately capture your information.
9 For those making public comment virtually please use the Raise Hand feature.
10 For those joining online or via telephone please note the following.
11 For Committee Members attending online please remember to unmute
12 yourselves when making a comment and mute yourself when not speaking.
13 Please state your name and organization before speaking. For our Committee
14 Members and our public attending online, as a reminder, you can join the Zoom
15 meeting on your phone should you experience a connection issue.
16 For the attendees on the phone, if you would like to ask a question
17 or make a comment please dial *9 and state your name and the organization you
18 are representing for the record.
19 For attendees participating online with microphone capabilities, you
20 may use the Raise Hand feature and you will be unmuted to ask your question or
21 leave a comment. To raise your hand click on the label titled Participants on the
22 bottom of your screen, then click the button labeled Raise Hand. Once you have
23 asked your question or provided a comment please click Lower Hand.
24 As a reminder, the Health Equity and Quality Committee is subject
25 to the Bagley-Keene Open Meeting Act. Operating in compliance with the

1 Bagley-Keene Act can sometimes feel inefficient and frustrating, but it is
2 essential to preserving the public's right to governmental transparency and
3 accountability. Among other things, the Bagley-Keene Act requires the
4 committee meetings to be open to the public. As such it is important that
5 Committee Members refrain from emailing, texting or otherwise communicating
6 with each other off the record during committee meetings because such
7 communications would not be open to the public and would violate the Act.
8 Likewise, the Bagley-Keene Act prohibits what are sometimes
9 referred to as serial meetings. A serial meeting would occur if a majority of the
10 Committee Members emailed, texted or spoke with each other outside of a Public
11 Health Equity and Quality Committee meeting about matters within the
12 Committee's purview. Such communications would be impermissible such as
13 number one emailing number two, who emails number three. Accordingly, we
14 ask that all members refrain from emailing or communicating with each other
15 about communication matters outside the confines of a public committee
16 meeting. That's all, Sarah.
17 MS. BROOKS: Just noting that -- thank you, Janel. Noting that the
18 meeting is subject to Bagley-Keene requirements. All right.
19 Slide 7 here walks through the agenda for today. We will have
20 welcome and introductions, review of the March 24 Meeting Summary. We will
21 move on and have an opportunity to have some continued discussion around
22 data quality experts, the panel that we heard from last time, both current and
23 future initiatives. We will talk a little bit about guiding principles for measure
24 selection, focus areas and disparities, we will have a discussion on measures
25 and then we will open it up for public comment and closing remarks from there.

1 So we have quite an agenda for us and we are excited about that today. Next
2 slide please.
3 So at this time I would like to do a quick roll call of DMHC
4 representatives Committee Members and then just introduce the Sellers Dorsey
5 team. All right. Mary Watanabe?
6 MS. WATANABE: I am here.
7 MS. BROOKS: Nathan Nau?
8 MR. NAU: Here.
9 MS. BROOKS: Chris Jaeger?
10 DR. JAEGER: Here.
11 MS. BROOKS: Sara Durston?
12 MS. DURSTON: Here.
13 MS. BROOKS: Next slide, please.
14 Anna Lee Amarnath?
15 MEMBER AMARNATH: Here.
16 MS. BROOKS: Bill Barcellona?
17 MEMBER BARCELLONA: Here.
18 MS. BROOKS: Dannie Ceseña?
19 MEMBER CESEÑA: Present.
20 MS. BROOKS: Alex Chen?
21 (No audible response.)
22 MS. BROOKS: Cheryl Damberg?
23 (No audible response.)
24 MS. BROOKS: Diana Douglas?
25 (No audible response.)

1 MS. BROOKS: Lishaun Francis?
2 MEMBER FRANCIS: Here.
3 (No audible response.)
4 MS. BROOKS: Next slide, please. Tiffany Huyenh-Cho?
5 MEMBER HUYENH-CHO: Present.
6 MS. BROOKS: Edward Juhn?
7 MEMBER JUHN: Here.
8 MS. BROOKS: Jeffrey Reynoso?
9 (No audible response.)
10 MS. BROOKS: Rick Riggs?
11 MEMBER RIGGS: Here.
12 MS. BROOKS: Bihu Sandhir?
13 MEMBER SANDHIR: Present.
14 MS. BROOKS: Kiran Savage-Sangwan?
15 MEMBER SAVAGE-SANGWAN: Present.
16 MS. BROOKS: Next slide, please. Rhonda Smith?
17 MEMBER SMITH: Here.
18 MS. BROOKS: Kristine is not joining us today.
19 Doreena Wong?
20 MEMBER WONG: Present.
21 MS. BROOKS: Silvia Yee?
22 (No audible response.)
23 MS. BROOKS: Next slide. All right, Palav Babaria?
24 MEMBER BABARIA: Present.
25 MS. BROOKS: Alice Chen?

1 (No audible response.)

2 MS. BROOKS: Stesha Hodges?

3 MEMBER HODGES: Present.

4 MS. BROOKS: Julia Logan?

5 MEMBER LOGAN: Here.

6 MS. BROOKS: And Robyn Strong?

7 (No audible response.)

8 MS. BROOKS: Next slide, please. And then this slide just
9 presents the group of individuals that are supporting this effort from Sellers
10 Dorsey. We will move on to the next slide from here.

11 So these materials that are presented on the slide here today will
12 be utilized throughout the meeting for discussion purposes and can be used as
13 reference documents as well. Committee Members should have received
14 several documents ahead of this meeting for your review including, I won't read
15 all of them, but an agenda, a presentation, a meeting summary, transcription, a
16 focus area reference document and then several workbooks that include different
17 measures. And recognizing we sent you a lot of information we appreciate that
18 you all had an opportunity to take a look at that. All right, next slide, please.

19 So just a little bit of information about where we are going and the
20 time line that we are on. We have scheduled meetings through August at this
21 point. There will be two Committee meetings in June, June 8th and the 22nd.
22 And the slides here do identify the steps which will be taken at each meeting to
23 accomplish our process. So maybe go back one slide, sorry. Thank you.

24 So you will see at this meeting today we will be talking about focus
25 areas and we have gone through kind of the process.

1 Next meeting we will be continuing to talk about focus areas as we
2 have 12 plus any additional ones that we may add for discussion purposes.
3 The next meeting we will go through a measure selection process
4 and we will go more in depth into this process later today. Next slide please.
5 The measure selection process will continue in June and then we
6 will move to benchmarking in July.
7 And then as I mentioned, we will have an opportunity to review the
8 draft report of committee recommendations in August. All right, next slide.
9 So we will now have an opportunity to take questions and
10 comments from Committee Members. As a reminder, please state your name
11 and organization before asking a question or comment. We will go ahead and
12 just check with Shaini to see if we have any hands raised. And as a reminder for
13 those in the room, please raise your hand as well online just so that we can make
14 sure that we are tracking everyone that has raised their hand. So Shaini, do we
15 have any hands raised? All right.
16 We will now take questions and comments from non-Committee
17 Members. We are going to go ahead and take public comment first. Shaini, are
18 there any hands raised? Anything? I don't see anything in the room so we will
19 move on to Slide 18. All right.
20 The March meeting summary is included in your meeting packets. I
21 hope that you all had an opportunity to review it and take a look at it. I just
22 wanted to check and see if there are any, if there is any feedback or any changes
23 that need to -- yes. Oh, I'm sorry, my apologies. I did not see that, the podium is
24 in the way. My apologies. Thank you.
25 REV. SHORTY: Good evening or afternoon. I came all the way

1 from South Los Angeles to address the Department of Managed Health Care and
2 this committee. I need each and every one of the members to understand the
3 decisions that you guys make are affecting a lot of underserved communities. I
4 see AltaMed, I see Cedars-Sinai, I see other organizations. But I want you to
5 keep in mind, the people that are hurting the most are the ones that doesn't have
6 easy access to facilities to provide the kind of health care that they are required
7 to have.

8 I looked at some of the issues. I understand smoking is one among
9 adolescents, which the Los Angeles County Board of Supervisors has already
10 addressed through other initiatives. And my soul aches because I notice we are
11 continuing to address the same old issues continually in the state of California
12 that is being addressed and we are leaving out issues.

13 I applied to get among this committee for the simple fact it doesn't
14 look like the community that it is supposed to represent. And it is shameful that
15 there is not one member of the community of the people that this Department of
16 Managed Health Care is supposed to help. You have a mission statement on the
17 wall that doesn't represent or speak volume at all in this state.

18 People are out there sick. When I pass by bus stops to see elderly
19 people sitting on a bus stop with fluid draining from their legs it is hurtful. People
20 are dying. Not just because they are homeless, they are dying because of the
21 lack of health care. And who do we blame for this? California is one of the
22 richest states in the world. People look to us for leadership. I came all the way
23 to address this committee because I am looking at each and every one of you
24 guys for leadership. Not to just be a suit or a person that is just sitting and
25 holding a seat.

1 You guys have had several meetings, it is all fine and dandy, but
2 the real issues that need to be addressed. Obesity. I worked in the mortuary
3 business over 20 years. I had to go back to our mortuary because we had over
4 300-plus bodies and a lot of those people that die from COVID had underlying
5 conditions and the most one was obesity. Some of them we couldn't even fit in a
6 casket. We had to have custom caskets built for them, cloth covered caskets.
7 And it was shameful. It is shameful for a family to have to put their loved one in
8 that type of cloth covered casket. And I just would explain to people, I don't think
9 that's befitting of how you would like to see a loved one leave this earth.
10 And there's a lot of issues that yes you are addressing but it's just
11 shameful. We can do better than this as California. And we are going to watch
12 this committee and we are going to look to each and every one of you all. There
13 was a time when they didn't want AltaMed coming into Watts. I fought for
14 AltaMed because they had a PACE program. They came in with a PACE
15 program. Because I would go to people's homes and they're dead mother,
16 grandfather or auntie or somebody would be laying on the floor because they
17 were left in a home because the children had to go to work. Then they'd come
18 home and in a panic uproar because ma had been laying on the floor dead for
19 five, six hours. And it's just shameful.
20 There's real issues here that we must begin to address in this state
21 and people are looking to you all for this leadership. Honestly, I mean, just to -- I
22 understand we don't want kids to smoke. We banned menthol cigarettes in
23 South Los Angeles, you know. But they are not talking about the fact that we
24 don't have access to adequate dieticians, adequate insulin supplies. The doctor
25 when you go to see him, he doesn't want to talk about obesity because he's got a

1 patient load that he tells me is outrageous and Medi-Cal don't want to pay. They
2 are the lowest paying insurance.
3 But yet we all took an oath to help people regardless of the money.
4 I don't do my work expecting to die and go to heaven with a Brinks truck behind
5 my hearse. Every funeral I have done I have never seen a Brinks truck behind
6 nobody's body. Never. So what you come here with is what you leave with. But
7 the one thing that matters the most is what you do on this earth. And I want you
8 guys to remember that because your decisions and the way you all are thinking --
9 I'm not here to preach to you. God will judge you on his own standards. But I'm
10 saying there are real issues that should be looked at in our state that affect real
11 people. Thank you.
12 MS. WATANABE: I would just like to thank you for making the trip
13 here and for the words that you shared with us. I will just say that we take this
14 responsibility very seriously and appreciate the concerns about obesity too. So I
15 just want you to know we appreciate the effort and the time you have taken to
16 come with us today.
17 MS. BROOKS: Thank you so much. Really appreciate your
18 comments, as Mary said, and apologies that I couldn't see you, that I missed you
19 before.
20 All right, so just circling back to the meeting summary. Wanted to
21 just check with the group here to see, and online, to see if there are any edits or
22 comments before we finalize them?
23 Silence that people are looking at the meeting summary or we do
24 not have any we have anything. Do we have hands raised, Shaini? From
25 panelists, no, at this point, though? So no comments from, okay, so we will go to

1 the next slide. So if we can open up the commenter online that would be great.
2 MS. MUÑOZ: Good afternoon. My name is Irma Muñoz and I am
3 the founder and executive officer of Mujeres de la Tierra. We work mostly in low-
4 income, immigrant and marginalized communities.
5 I will tell you that I am quite stunned when I look at the makeup of
6 this committee, especially with the governor's equity measure that was so much
7 applauded and discussed. My organization works with women and children.
8 And what we find is that people really want to be engaged. They want to provide
9 opinion and thought and discussion on issues that are very important to them.
10 And one of the top issues has become, especially since COVID, is their health
11 and access to health, good quality health.
12 And it seems to me that one of the things that you may want to
13 consider is to have your meetings in different parts of the state where these
14 community members can talk to you and you can listen. You are looking at
15 things through a professional perspective and lens. You need to look at it
16 through the folks you are trying to support and help and guide policy for. There is
17 nothing more powerful than having a listening session to listen to folks in many
18 different languages telling you what their needs are through what they have
19 experienced, as opposed to your thoughts about what they want.
20 Obesity and diabetes is probably one of the top killers in
21 communities of color and they go hand in hand. They were referred to as
22 underlying conditions during COVID. Well, I have underlying conditions and I
23 almost died from COVID; I had COVID, twice. And I decided to stay at home and
24 not go to the hospital because I thought I would die in the hospital. And there are
25 a lot of people who are very scared of going to medical, getting professional

1 medical attention because people just don't understand the cultural nuances.
2 And in a state that is majority of color with many languages spoken,
3 all committees that develop policy need to reflect that diversity and that opinion.
4 So I am urging this committee to have their meetings in different parts of the
5 state of California. You just heard from a reverend. I am sure he would love to
6 host you in Watts. I would love to host you, I am from Los Angeles, in the
7 Northeast Los Angeles area, so the -- so you can hear what people are thinking
8 and feeling and the frustrations they have had for so long.
9 First of all, lack of insurance. Many people go to non-traditional
10 medicine because they don't have no other choice. This is a historic moment for
11 you, for Californians and for all of us in the medical industry. Be leaders, be
12 courageous, be thoughtful, be engaging. Because we really need you to be a
13 2022 committee that understands the folks that they are serving, the folks they
14 are going to make decisions for, with their input. So I ask you, challenge you to
15 have community listening sessions so that you hear from the constituents that
16 you are doing your work for. Thank you so much for your time and attention, I
17 appreciate the opportunity to speak to you.
18 MS. BROOKS: Thank you so much for your comments, we really
19 appreciate them and they are meaningful. We will -- let me just see, Shaini, if
20 there are any other hands raised? Not at this time, okay. All right.
21 We are going to go ahead and finalize the meeting summary from
22 the March 24th meeting and it will be posted on the website for those that would
23 like to obtain a copy of it.
24 All right. So I think we need to move forward to slide 21 at this
25 point. Here we go. All right. So we are going to have a continued discussion

1 today. So we are really lucky to have a couple of data quality expert panel
2 individuals with us today. So we are joined by Anna Lee Amarnath and
3 Dr. Rachel Harrington. And let me just see if she has been moved over to the
4 Panelist side; is that right? She is able to -- okay, great. Unfortunately, Cheryl
5 Damberg is not able to join us today but certainly we will take back any
6 comments to her and have any discussion that might need to be had with her as
7 follow-up.
8 So just a friendly reminder to the Panelists and to those in the room
9 to avoid using acronyms without defining them and to explain technical concepts.
10 As we all know, we love those acronyms and the technical concepts but we want
11 to make sure we are all speaking the same language to each other. All right, so
12 next slide, please.
13 So last meeting this group provided us with an overview of the work
14 that they have done to date to enhance health equity and quality in California.
15 We did run into time constraints, as we know, during the quality expert data panel
16 and just wanted to open the conversation back up to the Committee to continue
17 this discussion today.
18 So with that we will see what kinds of comments or questions
19 individuals may have. As you can see on the slide, there's a little bit of summary
20 about what we heard previously. I will check with Shaini just to see if there are
21 any hands raised from Panelists. Anything from the public? Okay, opportunity.
22 We just wanted to -- one came up. All right, great. You may go ahead and open
23 up that line. There's Rick. Is your mic on? Just to make sure.
24 MEMBER RIGGS: Hi, this is Rick Riggs from Cedar-Sinai. And I
25 think that in reflecting on the reassignment, I think the discussion that we had

1 around those measures was sort of in real-time and so I think if we can bring
2 back some of the tenets of that as we move through today's session that would
3 be helpful if there were things that were highlighted. Because I think that we, we
4 talked about, you know, structures and functions and durability and lots of
5 different technical pieces. So if we can tie those into today's discussion I think it
6 will be more beneficial as we look at the measures that we are going to map out
7 today around, you know, prevention and chronic conditions and mental health, et
8 cetera.
9 MS. BROOKS: I think that is an excellent comment and definitely
10 we will lean on our partners Anna Lee and Rachel to contribute to that, and
11 others in the room that have all the expertise as well. All right. So it sounds like
12 we have another hand up, Doreena. Is that a mic? Bill, could you pass your mic
13 to her.
14 MEMBER WONG: Thank you. Is that, is that, that's -- okay.
15 Thank you very much. Yes. I guess I apologize. I know that we were supposed
16 to send in questions, you know, between, before this particular meeting. But I
17 have to admit, I didn't quite have enough time to pull together the questions to
18 send and so a couple of questions. One is, is it -- can I still send in questions if I
19 have questions specifically related to some of the presentations? Or I guess I
20 had just a more general question about when the expert panels were talking I
21 was wondering if there was any kind --
22 THE REPORTER: Excuse me. Speaker, could you please identify
23 yourself for the people online?
24 MEMBER WONG: Oh. Oh, okay, thank you. Thank you for
25 pointing that out. Doreena Wong from Asian Resources, Inc. So I was just trying

1 to see if the speaker -- at any rate, I just had a general question about the type of
2 data that all of the different committee, the NCQA, IHA and the RAND
3 Corporation was using. Whether or not any of the data they had was using kind
4 of disaggregated racial and ethnic data? Just because I think as a starting point
5 we should think about doing that in order to be able to identify the health
6 disparities among different subpopulations, you know, racial and ethnic groups.
7 But I could have a more specific question if I had time to address the particular
8 presentations.
9 MS. BROOKS: Thank you, Doreena. With respect to your
10 question about is there more time to ask more questions? Yes. Please send us
11 your questions. We want this to be an open dialogue ongoing. If you have a
12 question at any time please just let us know. We will circle back. We need to
13 make sure we are following Bagley-Keene with respect to kind of following up
14 and providing information but yes, if questions come up, please let us know.
15 Maybe I can lean on Anna Lee and Rachel to respond.
16 MEMBER AMARNATH: Sure. Hello, everyone. Anna Lee
17 Amarnath from Integrated Healthcare Association. So for our program, our
18 voluntary program where we record quality performance measures for health
19 plans and provider organizations, we are reporting race and ethnicity at what you
20 would refer to as the aggregated higher level that aligns with the OMB kind of
21 categories. That is the level at which the data is reported to us and collected to
22 us through the files that are submitted to us.
23 But I just wanted to reflect and say I understand kind of in general
24 there would be a lot of benefit if we are able to move towards gathering and
25 collecting information at a more disaggregated level. And there are different

1 people on this committee and at different state agencies who have the
2 opportunity to disaggregate that information and look at different subpopulations
3 and think there can be a lot to learn from that. So that's definitely an area that we
4 would like to look to move into. But again, we need to collect data in a way that
5 is aligned with how it's being collected at other entities and organizations. So
6 that is just speaking for IHA.
7 MS. BROOKS: Rachel, I don't know if you had any additional
8 comments to add?
9 MS. HARRINGTON: Yes. Hi, Rachel Harrington, National
10 Committee for Quality Assurance. So I do. I think similar to Anna Lee, the
11 NCQA HEDIS the set of quality measures that we have reported by race and
12 ethnicity, the reporting that comes to us for an accountability purpose is also
13 done at approximately the Office of Management Budget level. We made a few
14 modifications to allow for a multi-racial category as well as for a patient
15 declination. So if somebody chooses not to respond to, to respect that as a
16 category in and of itself. But generally, we are still using the OMB categories.
17 And we acknowledge that those have some pretty significant
18 limitations, one of them being the inability to disaggregate on disparities in Asian
19 communities and in Black or African American communities and, you know, the
20 wealth of diversity that we have within those larger aggregate buckets.
21 I think one recommendation or insight that I might share on this is
22 there is a difference between reporting and collection. As Emily was saying, if
23 you collect it you can collect it at a more granular data level than that. Use that
24 for your intervention planning, your quality improvement, to do some of that more
25 nuanced assessment. And there are tools out there, one of them comes from the

1 CDC, they have a tool that they published that allows you to roll up and down
2 between different levels of data. So if you collect it at the more nuanced level
3 you could use that and then if you need to, for sample size or purposes of
4 comparison between different geographies that maybe don't have the same
5 nuanced populations, you can then roll it up to higher levels for use for different
6 purposes. So we would definitely suggest, you know, if you have the option to
7 collect it out at more nuanced categories, to do so.
8 I would also point, and I am happy to look for the link to share with
9 the Committee as well, the state of Minnesota has done some really interesting
10 work on this in their all-payer efforts around equity. They particularly have looked
11 at how you sort of look at Black and African American populations when you
12 have populations coming from Africa who are going to have a very different sort
13 of social and community structure than African Americans might. And so I know
14 that that's been a particular consideration for them and they have done a lot of
15 work on how to disaggregate and re-aggregate data for purposes of quality in
16 that sense.
17 MS. BROOKS: Thank you, Rachel. I just wanted to check,
18 Ignatius, did you have any additional comments there? No. Rhonda, I see your
19 hand is up.
20 MEMBER SMITH: Great. Rhonda Smith, California Black Health
21 Network. And I was saying, I just wanted to share some thoughts and
22 observations and feedback on the last discussion and trying to discern what I
23 wrote in my notes about it. And so when we think about, I think health equity and
24 how we measure that or, you know, what the metrics are going to be, I think it is
25 important for us to also consider sort of the cause and effect, right? So what we

1 saw from some of the metrics at the last meeting were more sort of the effect of
2 what health care is being delivered and the quality of that, so from the patient
3 perspective.
4 But I think if we are really going to achieve health equity and
5 improve what patients experience I think it is important to really think about how
6 are we really driving health equity from the health care delivery perspective in
7 that system of care, and not just kind of what happens after the fact. But making
8 sure we go further upstream so that it is not just about the patient but it is also
9 the provider and the system that is delivering that health care and how we can
10 make sure that we are driving health equity and quality care from that
11 perspective. If that all makes sense if I remember my notes correctly, yes.
12 MS. BROOKS: Great notes, thank you. We appreciate your
13 comments, they are very helpful. It looks like, Kiran, you have your hand raised.
14 MEMBER SAVAGE-SANGWAN: Sure. Kiran Savage, CPEHN. I
15 think just on the data. To Doreena's point, it would be helpful to get some
16 clarification because I know for this meeting we have all the lists of measures
17 and the team has identified which ones meet the disparities-sensitive criteria.
18 But I think I am still struggling to understand sort of what data does the
19 Department feel like all the health plans have when it comes to race/ethnicity in
20 particular, to what extent is that standardized so that you can hold plans
21 accountable? Like, I think I have just sort of felt like we are maybe skipping a
22 step here if we are going to talk about equity in quality measurement and so I am
23 just wondering if there has been any further thought either from the consultant
24 team or from the Department about just making sure that we have sort of a level
25 set on what kind of race, ethnicity, language, et cetera data is available or not

1 that would help inform the choice of measures.

2 MS. BROOKS: Great question or comment, Kiran. We are going

3 to talk a little bit about that today, Ignatius is going to touch on that later. I don't

4 know if you have any initial comments Ignatius, or maybe we just --

5 MR. BAU: Ignatius Bau from Sellers Dorsey. So in response to

6 both Rhonda and Kiran's question, these might be when we later get on to the

7 different types of measures. These might be the structural measures to actually

8 create a measure that is measuring the completeness of the race, ethnicity, or

9 other demographic data as a first step and so that is one, one way that this

10 committee could recommend a measure that would actually get at that. We are

11 also making the assumption that when the measures are selected by the

12 Department that obviously if ultimately the data is missing then the plans are also

13 going to report that and then it will be up to the Department to decide, you know,

14 how then it is going to work with the plans to increase the completeness of that

15 data. That is always going to be an issue regardless of the measure being

16 chosen, not just in terms of the race, ethnicity or other demographic stratification.

17 MS. BROOKS: Thank you, Ignatius; and great question. Silvia, it

18 looks like your hand is up.

19 MEMBER YEE: Hi, this is Silvia Yee, DREDF. I think it, I thought it

20 was. This is Silvia Yee, DREDF. It is just a quick question. I apologize, I was

21 late getting here and so you may have already said this. But I think, I think we,

22 there were questions that were submitted after the last one and I was just

23 wondering when we would, when we should look for responses to that, or did I

24 miss it? That is also a possibility.

25 MS. BROOKS: Yes, so we didn't receive any questions. Now you

1 had, there was one question that you had posed during the last meeting but we
2 didn't receive any additional questions after or comments after --
3 MEMBER YEE: Oh, right.
4 MS. BROOKS: -- the meeting itself.
5 MEMBER YEE: Oh, okay. So when would the response to that
6 question be?
7 MS. BROOKS: Let me pull it up right now and then I can talk to
8 you about it.
9 MEMBER YEE: Yes. Sure, that's fine, thank you.
10 MS. KANEMARU: During the last meeting, Silvia, you had asked, I
11 had one additional and very specific question for the initial set of presenters that I
12 would like to include in the post-meeting Q&A if possible. The RAND
13 presentation -- in the RAND presentation Ms. Damberg spoke of using risk
14 adjusted measures to try and distinguish between within provider disparities and
15 between provider disparities. In the NCQA presentation, Ms. Harrington
16 indicated that they excluded risk adjusted measures as candidates for the five
17 additional measures they were selecting for stratification. It might be that the two
18 risk adjustment references or speaking to risk adjustment that takes place at
19 different times in the collection and aggregation of information. I would
20 appreciate hearing explicitly how the two considerations for and against risk
21 adjustment can be reconciled.
22 MS. BROOKS: All right. Thank you, Alex. Silvia, I apologize that I
23 didn't have that pulled up right away. I wonder, Anna Lee or Rachel, if you all
24 have any comments with respect to Silvia's question or comment?
25 MEMBER YEE: I think it might be hard to address without the

1 context of the -- it was -- I mean, you sort of have to know what her presentation
2 was. I mean, maybe you could answer it now but it seems like it is quite difficult.
3 MS. HARRINGTON: So if I may. Hi, Silvia, this is Rachel
4 Harrington speaking. I don't fully recall Cheryl's presentation but I believe the
5 way you framed your question is correct, that we were talking about it in two
6 slightly different ways. I think they were discussing it more in the ways that you
7 can use the statistical methods around risk adjustment to understand variation at
8 different levels.
9 When we were referencing it in terms of NCQA's work it was very
10 specifically that when we were selecting measures for stratification by race and
11 ethnicity for that very first pilot pass that we did in HEDIS, we have a set of risk
12 adjusted measures in HEDIS. These are measures with statistical models
13 behind them that calculated an expected rate, you compare it to the observed
14 rate, and you use that as a way of judging performance.
15 In our first year of stratification we excluded those measures
16 because of the technical complexity of them. Because we considered this a pilot
17 process we wanted to stick to measures that were more straightforward, had
18 fewer sample size considerations around them. It didn't necessarily get into
19 some of the statistical nuance and just start with a more feasible portfolio, which
20 is why we selected the five we did. It's not to say that you can't stratify risk
21 adjusted measures, you certainly can. It was just, it was more of a feasibility
22 decision from our end to help support the HEDIS community in doing this work.
23 So I don't think it is necessarily a barrier should the committee choose to select a
24 risk adjusted measure and I do think it is separate from the considerations that
25 were being discussed by RAND.

1 MEMBER YEE: Thank you.
2 MS. BROOKS: Thank you, Silvia and Rachel. Bihu.
3 MEMBER SANDHIR: This is Bihu Sandhir, I am from AltaMed.
4 The question I have, I think it was Rachel in the last meeting, you had presented
5 about how you had -- CMS or Medicare had the health equity index that was
6 being incorporated into these measures so that way, we would encourage health
7 systems to take care of our most vulnerable population of patients, because that
8 is also a factor when we are choosing measures. So what I ask is that when we
9 move forward with this we also keep that in, to take that into account so that way
10 we encourage, we build that in so that we encourage our health systems to
11 actually take care of our most vulnerable patients. Because I think that has been
12 a barrier in the past and if we can address that. That would be, I think, helpful.
13 MS. BROOKS: Thank you, Bihu. It looks like, Ed, you have your
14 hand up.
15 MEMBER JUHN: Hi, Ed Juhn, Inland Empire Health Plan. Two
16 questions. The first question is, have we as a committee aligned on the
17 definitions of race and ethnicity based on the OMB criteria? And the second
18 question is, and maybe our experts can weigh in, Anna, or Rachel, if people self-
19 identify as having more than one race is that also going to be part of the
20 discussions when we think about some of the specific quality measures and how
21 we think about stratifying members who might identify with more than one?
22 MS. BROOKS: We haven't yet had discussion. I am looking at
23 Ignatius and maybe you want to make a few comments because I know that we
24 haven't had discussion on that yet.
25 MR. BAU: This is Ignatius Bau. Again, we haven't had the

1 discussion but my working assumption is, if for example, the Committee
2 recommends one of the five HEDIS measures, the NCQA, National Committee
3 for Quality Assurance measures that they will be requiring stratification by race
4 and ethnicity starting this year, that we would use the way that NCQA in the
5 measure specifications defines race and ethnicity. As Rachel described, it is
6 generally the Office of Management and Budget categories with the additions of
7 the multi-racial option and the decline to state option.
8 I think the open question is, if there is a measure that the
9 committee recommends where there is no consistent stratification by race and
10 ethnicity, does the Committee then further make a recommendation about how to
11 do that stratification? Particularly in California with more diverse racial and ethnic
12 subgroups are there other conventions or categorizations? For example, the
13 ones that Covered California uses and Medi-Cal uses in their enrollment forms
14 would be an option to look at.
15 MS. BROOKS: Thank you, Ignatius.
16 MEMBER AMARNATH: This is Anna Lee Amarnath for the
17 Integrated Health Care Association. And just to kind of add to that, I think there's
18 sort of a couple of layers to that question. One is have we decided how to define
19 race and ethnic categories? And I think that there is, there is a difference
20 between defining the categories versus defining how you are collecting the
21 categories versus defining how you are going to use what you have collected for
22 reporting. So for example, I know the OMB categories have come up quite a bit.
23 It is common to see and a lot of ways that data is being reported currently
24 alignment with those categories.
25 However, data may be collected in ways that allows for different

1 disaggregation from those categories, or even capturing more than one answer
2 for that category. So for example, a data file may allow collection of data of one,
3 two, three, four, as many categories of race as that file allows for collection. How
4 that is then utilized for reporting may allow for categories to be combined to
5 identify someone of mixed race, or as NCQA has pointed out, their way of
6 modifying the OMB categories to allow for simple selection of a mixed race
7 identification. So there's lots of different ways that we could think about that at
8 different levels.
9 And I guess I also just wanted to maybe question. Choosing the
10 measures does not necessarily, I don't think, have to define how, how those
11 measures are then stratified. As a baseline it does make a lot of sense to think
12 about if there is an existing measure in the existing specification on how to
13 stratify by race and ethnicity, that is a great starting place. But there may be
14 reasons why we want to think about adjustments in California that might make
15 sense that utilize the data that we have in a way that might be a little bit more
16 granular than what is required to be collected for HEDIS purposes.
17 So I think that there's a couple of different ways that we can talk
18 about that and I have a feeling that starts to get really technical and people don't
19 want to talk about file formats. Well, some of us do. So I think that we can think
20 about that maybe a little bit in a more open way. It's a great idea to start at a
21 baseline with what's already done but I think that there's opportunity to look at
22 what we can do in California right now that might be more or where do we want
23 to go? And that's also, I think, a part of what this Committee can help inform is,
24 where are we going? How are we going to define the way data should be
25 collected and reported through other efforts like the data exchange framework

1 that's happening and thinking about how that should be collected through other
2 efforts that people around this table are a part of as well. Thank you.
3 MS. BROOKS: Great comments. And, Ed, I think what you have
4 hit here is that we have a conversation to have coming up about this and some
5 really interesting kind of dialogue to have based on the responses we received
6 so thank you for raising that.
7 All right, I don't see any other hands raised at this time from the
8 Committee Members. Let me just make sure. Anybody else? I am going to wait
9 the 12 seconds I guess it says to wait.
10 Shaini, do we have any non-committee members that have raised
11 their hands? Not at this time, all right.
12 Let's see, we are -- where are we? I believe we should move on to
13 Slide 25. All right.
14 So last meeting we began the conversation on the guiding
15 principles for measure selection and during today's Committee we will continue
16 that conversation as well as give an overview on key terminology and just review
17 the overall process for measure selection that we are thinking about. Just to be
18 clear up front, this is a discussion here so we are putting out there some ideas.
19 We welcome your feedback and look forward to hearing from you all with respect
20 to it. All right, so next slide, please.
21 So as mentioned in the earlier Committee meetings and today, the
22 goal of this Committee is to make recommendations to the DMHC for standard
23 health equity and quality measures, including annual benchmarks used to assess
24 quality and equity in California.
25 These recommended measures, as you know, will be used for full-

1 service plans and behavioral health plans as well. So just want to kind of flag
2 that as we are thinking about what types of measures we are selecting and who it
3 will be applicable to. Next slide.
4 So before we get into the guiding principles we will just review
5 some key terms that will be used throughout the process.
6 In accordance with, that sounds so formal, but in accordance with
7 the definitions provided by CMS, Medicaid and other industry leaders, a measure
8 is an activity or outcome that is monitored and evaluated to determine if it
9 conforms to standards. So we will be discussing measures in further detail later
10 today when we discuss focus areas and at that time I will kind of define focus
11 areas. And we talked a little bit about that last meeting but we will dive into that a
12 little bit more in-depth then. Next slide.
13 So measures are typically categorized as either a structure,
14 process or outcome measure. This classification system is known, I love this, as
15 the Donabedian model, named after the physician and researcher who
16 formulated it. The classification has since expanded to include patient
17 experience as well.
18 As such, throughout this process there are four different types of
19 measures to consider: Structural, which assesses a provider's systems, capacity
20 and processes to provide high-quality care. Process, which identifies if an action
21 takes place. Outcome measures, which evaluate the impact of a particular
22 intervention. And just noting that, as we know, outcome measures can take time
23 to improve, right? And then finally, patient experience, which reflects the
24 patients' perspective on the care received. Often these are reported through the
25 CAP survey, you are probably familiar with those surveys.

1 You will notice in the measures workbooks that you were sent, I am
2 sure you all looked at every single measure that we send to you, right? You
3 received in your meeting packet, that there is a column labeled Measure Type
4 that categorizes each measure.
5 During the last meeting we heard that there was not enough focus
6 on outcome measures so this is one of the things we want to make sure that we
7 note as we review measures later in the meeting, just continuing to talk about the
8 different types of measures and if they are applicable or not. All right, next slide.
9 We are going to go through a few different kinds of key terms.
10 Forgive me if these are ones that you know very well and ask questions if there
11 are questions, please.
12 We will start with Targets. So Targets will be referred to throughout
13 this process to describe something that has a specific and measurable objective
14 against which performance can be judged. For example, meeting or exceeding a
15 screening rate in the first year of implementation and so forth.
16 Benchmarks provide a standard or goal which a comparison can be
17 made to evaluate overall performance. For example, a standard or goal which a
18 comparison can be made to evaluate overall performance. I'm sorry. For
19 example, when discussing the average performance of the top 10 percent of
20 entities on breast cancer screening or those which are in the 90th percentile.
21 All right, Baseline is the next term. This is typically starting the
22 point of a measure which may be monitoring and improved against or compared
23 to. So for example, comparing the rate of breast cancer screening of 25 percent
24 at Year Zero an subsequent years. Next slide.
25 So at a very high level, this is the process, the proposed process

1 for measure selection and may change based on Committee needs and
2 expectations. So we are going to walk through what we are thinking. We want
3 your feedback. We want to have discussion about this and so welcome that as
4 we move through. All right.
5 So during this meeting and the May meeting we will be reviewing
6 and prioritizing measures by focus areas. Candidate measures will be selected
7 for further review and discussion by the Committee.
8 By June, with two meetings, our goal is to review the prioritized
9 measure of the top two to three candidate measures by focus area to develop the
10 final measure set.
11 In July, we will review, identify and finalize benchmarks.
12 And then during our last meeting in August we will focus on
13 reviewing the draft report of recommendations. Committee Members will have
14 an opportunity to review and provide feedback to the report prior to the August
15 meeting, during and after the meeting, so lots of opportunity for comment.
16 You will notice that there is benchmarking data in the workbooks.
17 Please feel free to look at it but just noting that we will likely discuss that more in
18 July. Just wanted to stay kind of out of the weeds at this point but definitely if
19 there are questions or comments we welcome them and we will have that
20 conversation. All right.
21 So as a reminder, this process is highly iterative and the
22 Committee's feedback and discussion will support the development of a
23 comprehensive measure set of measures of existing or proposed measures.
24 Throughout the selection process we will note recommendations that may not be
25 currently feasible, but may be included in the future. Next slide.

1 So at this time we will just open it up to the Committee to have a
2 discussion to see what kind of questions there are. If there is any needed
3 clarification on any of the Committee goals, the key terms or the process for
4 measure selection. And I will look, I see -- maybe there is a question over here
5 but I will look to see, Shaini, if we have any hands raised from Committee
6 Members. All right, Rick.
7 MEMBER RIGGS: Hi, this is Rick Riggs. So do you think we are
8 allowed to link any of those if we have an if-then? For instance, if we have
9 chlamydia, chlamydia screening do we, can we also ask for the outcome
10 measure of how many were, received treatment?
11 Or if there's a, you know, breast, a mammography breast cancer
12 screening are we allowed to know how many of those had subsequent follow-up
13 for positive findings? I think that's the, you know, sort of. The screening, the
14 process pieces, oftentimes we think will lead to outcome measures but are we
15 allowed to kind of bundle?
16 MS. BROOKS: To bundle measures. I see Andy. Let me just turn
17 it over and see what Andy has to say.
18 DR. BASKIN: Yes. So all of that, it is Andy Baskin from Sellers
19 Dorsey, a consultant. All of that is possible. Now, to the extent that those
20 measures may not currently exist. If they do great, you can, anybody can
21 recommend that we actually discussed that, you know, that outcome measure
22 that ties to the prevention screening measure. If it doesn't exist then you can
23 make the recommendation that such a measure be created. That would take
24 some time, of course, but no doubt that would be something that is meaningful to
25 do so we are not we are not putting any limitation on that. I will stop at that

1 unless that didn't answer your question.

2 MEMBER RIGGS: No, it does. You know, for instance, I know that

3 we monitor our fail rate for positive breast cancer and that is -- I don't know

4 where that is submitted as a data point but, you know, it is one of those things

5 that we report. And so it seems as if we are going to impact or strive to impact

6 how we are going to challenge our health plans in the state to really move the

7 needle that we may want to think about some of those, not just the four buckets.

8 DR. BASKIN: And just to finish up. I understand that there are

9 some institutions that do measure those types of outcomes, for instance, breast

10 cancer screening and failure rates and things like that. To the extent that either

11 you can identify or we will take it back to look further to see if there's an existing

12 specification out there, a measure that we could then propose, that would be

13 great, we will do that research if we haven't found one already. And to the extent

14 that we can't find one, we can certainly as a group recommend that one be

15 created and we could, look to institutions like yours or others to try and help

16 create that measure.

17 MEMBER RIGGS: Right. And this is Rick, again, for the court

18 reporter, I know it's hard for you to keep track, this is records again. So, right. I

19 guess what I was saying is I guess if we put up process measure in year one,

20 since this is supposed to be a five year run, could we say, and by year three, you

21 know, could we report on number of referral or referral for treatment or received

22 treatment?

23 DR. BASKIN: My understanding is the answer is yes, you can

24 make whatever, this Committee can make whatever recommendations they think

25 are appropriate.

1 MS. BROOKS: Did you have a comment, Mary?
2 MS. WATANABE: Yeah, no. And this is Mary Watanabe, the
3 Director of Department of Mental Health Care. The only caution I have is we
4 really, our intent here was to establish a core set of measures. We need to
5 codify them in regulations in order to take enforcement action so I would just
6 remind everybody of the little nuance we have. We don't have contracts with the
7 health plans, we are the regulators, so we need things in regulation to give us
8 teeth to enforce.
9 So, you know, I will just say, overall we, this is not our area of
10 expertise as the DMHC, this is new work for us, so we really are looking for you
11 to be innovative and creative and advise us. Knowing that there are some
12 constraints we want to make sure, you know, that we have good data so that we
13 can enforce these. But I am a little reluctant to put too many guardrails on you
14 because I do think there are some unique opportunities here for us to think about
15 things about like linking measures. But that one year versus what we would do in
16 the third year, that could create some issues just from a regulation perspective.
17 MS. BROOKS: Does that make sense? You can say no if it
18 doesn't.
19 MEMBER RIGGS: Yes, it makes sense. And I think a regulation
20 that was written in the correct format could say that we expect treatment, we
21 expect referral for treatment or received treatment, you know, reporting at year
22 three or four or whatever.
23 MS. WATANABE: So it would be like you would measure
24 something in year one and also in year three for the same population?
25 MEMBER RIGGS: You would, you would have a process measure

1 that you got screened for breast cancer, year one. Perhaps year three or four
2 the outcome, by that time we would expect to understand, whatever, grade X
3 percent of that had follow-up treatment, follow-up referral.
4 MS. WATANABE: So the benchmark, I know we are not talking
5 benchmarks yet, but the benchmark would be tied potentially to both pieces.
6 MEMBER RIGGS: Right.
7 MS. WATANABE: Or the subsequent measurement in year three
8 or four.
9 MEMBER RIGGS: Right, standard rates of actually conversion that
10 do exist probably for those types of large, you know, screening sets that have
11 happened.
12 MS. WATANABE: Nathan and I are nodding that yes, that sounds
13 like something we could do. And Sarah too, yes.
14 MR. NAU: And Nathan Nau, Department of Managed Health Care,
15 just a reminder that the workbooks that Sarah keeps mentioning, I just want to
16 point out they are online, we are not going to take them down, they will remain.
17 A lot of good information in there so if you need it later for research they will be
18 on the website.
19 MS. BROOKS: Thanks, Nathan. All right. And Rick, I just want to
20 thank you for re-announcing yourself. Just a friendly reminder to everybody in
21 the room and on the Zoom to say your name and your affiliation, both for
22 transcription purposes but just also it sounds like people can't see us necessarily
23 and know who is speaking if they are looking online so that is important. All right.
24 It looks like, Ed, you have got your hand up.
25 MEMBER JUHN: Thank you. Ed Juhn, Inland Empire Health Plan.

1 A comment. I just encourage the Committee to consider taking into account
2 geographic variance when it comes to the actual measures, whether they are
3 process or outcome measures. Having individuals benchmark based on their
4 baseline might be a reasonable starting point, given that if we set a number out
5 of the gate, different regions with different challenges might have more, I guess,
6 have more of an opportunity to reach those benchmarks versus other regions.
7 So just thought that I'd share that for consideration. Thank you.
8 MS. BROOKS: Thank you, Ed. Any other comments from the
9 Committee Members? I see Bihu has her hand up.
10 MEMBER SANDHIR: I am Bihu Sandhir from AltaMed. I actually
11 agree with the outcome measures and I like the concept of over five years that
12 you actually have a couple of years to actually see how to develop a process;
13 and then you are looking at outcomes of what process that you actually --
14 whether it worked or what did it do.
15 I just caution us. I think we have to build it in but I caution us that
16 we -- what I worry about with that is that we just want to make sure that it is
17 something we can actually measure. That we have the ability to measure. It
18 shouldn't be a burden on the, on the, you know. This translates all the way down
19 to the patient level. It is not just from the managed care. Whatever the managed
20 care, they will bring it down to patient level. We have to be able to report it. And
21 so we want to -- I think that needs to really be considered.
22 So what I asked is for recommendations from our subject matter
23 experts here on what can actually be reported and, you know. And then also,
24 what are we going to do with that information? It is great to report it but what is,
25 what is the end point here with that?

1 So I think that has to all be taken into consideration with any quality
2 measure that we pick. And definitely the equity part is very important but also all
3 of these factors play into how these measures work out all the way down to the
4 grassroots level.
5 MS. BROOKS: Great points, thank you so much, Bihu. Any other
6 comments from Committee Members?
7 Do we have any comments from the public, Shaini? No more
8 additional comments before we move on. All right. So we will move on to Slide
9 34. All right.
10 So as Nathan mentioned, we are not going to be pulling up the
11 workbooks that we are going to be talking about. I will provide you some
12 direction here in terms of
13 what to be looking at and what to consider and whatnot in the workbooks. As he
14 noted, they are available online. And just recognizing that it's a lot of information
15 that we provided to you all and know that, and hope that it is helpful to you.
16 All right, so we are going to talk a little bit about the guiding
17 principles for measure selection. The principles for measure selection are based
18 on common themes seen at the state, national, federal and other organizational
19 levels and in accordance with the goals of this specific initiative with this
20 Committee. So while we do not expect to present them as a voting item today, if
21 there is consensus for some adjustments to the principles then, then they will be
22 considered for incorporation into the report.
23 Ultimately, the criteria are not meant to be absolute or literal but to
24 provide guidance in thinking about measure selection and the balance of the
25 entire set as a whole.

1 These principles for measure selection should not limit you from
2 suggesting additional or new measures throughout this process. If there are
3 other criteria you would like to present to the, present to the Committee, please
4 feel free to express them during the comment period for the group's
5 consideration. Next slide.
6 The principles listed here. We will go through these just briefly and
7 we saw a little bit of these last meeting, include:
8 Number 1, alignment with our other measurement and reporting
9 programs, including California-specific programs as well as federal initiatives.
10 Considering the extent to which there is opportunity for
11 improvement within a measure and that an improvement would enhance health
12 outcomes for specific high-impact aspect of health care.
13 Similarly, the opportunity to identify and reduce disparities in race,
14 ethnicity or other variables will need to be considered. Next slide, thank you, 36,
15 yes.
16 That there is also the matter of feasibility around the extent to which
17 required data is available or there are capabilities to collect and stratify data
18 without undue burden. And just wanted to kind of see from the state or any
19 health plan partners if there were any specific comments on that specifically.
20 Nothing at this time, okay.
21 Additionally, the magnitude that other audiences are using or could
22 use the performance data for improvement should be considered as well.
23 As well as how the quality measures fit into California's overall
24 priorities.
25 So again here we are back to Committee discussion. Let's go back

1 and just leave the Committee discussion questions up, yes. So a couple of
2 questions for the Committee itself.
3 Are these the correct guiding principles for measure selection for
4 this Committee?
5 And then, does the Committee have any additional feedback on
6 these principles?
7 So with that we will open it up for comment and discussion. It looks
8 like Alice has her hand up.
9 MEMBER CHEN: Alice Chen from Covered California, Really
10 appreciate these principles, I think they capture the high level important
11 concepts. I do want to reiterate the importance of alignment. We have
12 experienced that in our work over the last few years with our health plans.
13 And I also wanted to raise a question which is, you know, there's a
14 balance between wanting outcome measures. I mean, I think issues of
15 screening are just the first step, obviously you want to make sure that you follow
16 that all the way out to follow-up for abnormal screening and treatment. The
17 question becomes whether or not we want to get involved in developing
18 measures. I personally would caution us given our time line against that. There
19 are so many measures out there already and so I wonder if part of these criteria
20 should include that we use established, validated measures, in part because if
21 we want to have benchmarks, particularly around the possibility of stratification
22 by different demographic factors, there has to be quite a bit of experience and a
23 track record, I think, before we can responsibly do that.
24 MS. BROOKS: I think it is fine to open it up to Alice's question.
25 MR. NAU: Hi, Nathan Nau, Department of Managed Health Care.

1 Given all the experts in the room I was just curious, has anybody participated in
2 actually creating a measure and a benchmark and if so I was just curious on
3 high-level time lines and how long that takes? I am specifically asking because
4 we would have to get to the benchmark stage for us to have any enforcement
5 opportunity.
6 MS. BROOKS: All right. So I see some hands up. I know we have
7 got a couple of people on our team but let's go to the people online first if that's
8 okay. I see, Rick, you have got your hand up.
9 MEMBER RIGGS: Right. I think it probably is better if we talk
10 about the time line first.
11 MS. BROOKS: Got it?
12 MEMBER RIGGS: Yes.
13 MS. BROOKS: All right, sorry. Palav, was your response in
14 response to Alice's question and comment?
15 MEMBER BABARIA: It was both. I think the time line, in my
16 experience having done this on the health care delivery system side and also --
17 sorry, Palav Babaria, Department of Health Care Services. And also on the state
18 side, it is usually about a two to five year process to really vet the measure, pilot
19 it, refine it based off of what we find can and cannot be collected. And then, you
20 know, once the measure spec is nailed down, everyone using it and having at
21 least a year's worth of data to create those benchmarks.
22 And then I will just say, you know, to piggyback off of what Alice
23 was saying, I think from the delivery system side alignment is critical. And it is
24 hard to find a parsimonious set but we will, we will see more of the results that
25 we want to see if providers and the delivery system side don't have 100 different

1 measures that vary from payer to payer or initiative to initiative. I second that it
2 would be really helpful.
3 And I think one of the values of this Committee in this work is really
4 trying to come up with what that measure set looks like across payers and across
5 all of our different systems, which is rare and unique. As we all know, you know,
6 we have our Medicaid approach or Medi-Cal approach, we have our Covered
7 California approach.
8 A lot of those have decisions are made at the federal level and not
9 necessarily at the state level, but really being able to see what is happening for
10 quality and equity, independent of what insurance-type people have or what the
11 delivery system is, I think is incredibly valuable. But we -- one of, you know, the
12 end terms of the guiding principles in terms of applicability, recognizing that
13 there's different benchmarks, there's different sort of disease prevalence and
14 incidence in each of these populations, trying to think through how can we thread
15 the needle so that we get to a set that, you know, covers everyone and gives us
16 that comparison would be valuable.
17 MS. BROOKS: Thank you, Palav.
18 Ed, is your comment in relationship to this?
19 MEMBER JUHN: Yes, Ed Juhn, Inland Empire Health Plan. Just I
20 think alignment is critical. In addition to that I think just alignment and how the
21 information is potentially collected or reported back to the health plan is going to
22 be at least pretty important. For example, for us here at the local health plans of
23 California, the collective Medi-Cal plans have recognized, for example, and we
24 don't have to get into files, but the 834 files, which we rely on, have race/ethnicity
25 fields that are mixed together. So again, as long as there's alignment in the

1 measure sets across the board here, but also the way that the information may
2 be relayed back to the health plan. Some consistency would be helpful,
3 especially if we are going to be held accountable to, you know, move, move the
4 needle forward.
5 MS. BROOKS: The 834 file is the eligibility file that goes to the
6 health plans, correct?
7 MEMBER JUHN: Yes.
8 MS. BROOKS: Let's see. Rachel, it looks like your hand is up.
9 MS. HARRINGTON: It is. Hi, Rachel Harrington, NCQA. This was
10 to speak to the question on timing but let me know if it's not the appropriate time
11 to jump in on that. Typically, as Paula said, it's typically at least a two year
12 process. We have seen measures developed in a year if they are linked to a
13 very clear guideline and concept that is already well vetted and sort of in practice
14 in the field but generally the measure development is on an up to two year time
15 line.
16 And then an important nuance there, at least at NCQA we typically
17 would never benchmark off the first year of data because there's a lot of
18 variability, people are still figuring things out. So you would want to wait at least
19 a year, get the first year and evaluate it, before you would put it into practice from
20 a benchmarking perspective. So that would say for the easiest of measure
21 concepts you are sort of two years from concept to potential benchmark, in most
22 cases three to four.
23 DR. BASKIN: Yes, so it's Andy Baskin from Sellers Dorsey. Yes,
24 that time line is about right; I have been on multiple technical expert panels
25 creating new measures. And just recently a new measure that NCQA adopted

1 for diabetes and nephropathy, I was on that panel, and from the date that it
2 began it was at least two years until it actually got to a form that it could actually
3 get to NCQA and then it had to go through a year of testing and whatever. So
4 yes, that time line is very appropriate. We have heard two to five and I think that
5 makes sense depending on the measure and that was actually a rather simple
6 concept measure so others take longer.
7 MS. BROOKS: Thank you. Anything else on this issue specifically
8 before we come back to your question, Robyn. All right, Robyn, and again, my
9 friendly reminder to introduce yourself.
10 MEMBER STRONG: Hello, my name is Robyn Strong and I am
11 with the Department of Health Care Access and Information so again, from the
12 state, from California. And actually we kind of morphed into a little bit of what my
13 comment was, was about. As Ed said, the focus on what is already being
14 collected through the claim forms, through their enrollment forms, is a great place
15 to start. And that if we can, to the first measure that you, that you have listed on,
16 on that screen, it talked about other reporting entities or -- remember, things that
17 are already in effect. But also looking at some of those structural pieces where
18 there is already communication between the provider and the plan and those,
19 focusing on those data elements that are already in there.
20 And going back to one of the comments I made last meeting, about
21 the completeness of even that data and starting there really bring that data into
22 completeness. Recognizing that the purpose in some of those, in the claim
23 forms is really to get the claim paid but there are so many other data elements
24 that are not required for claim payment that we can maybe use leverage through,
25 through the regulations, et cetera, to get them completed to serve some of our

1 purposes. So really focusing on some of those standards that are beside the
2 reporting that exist in some of the structure that is already well established in
3 national standard.
4 MS. BROOKS: Very helpful, Robyn. Just comments or feedback
5 in response to Robyn's comment? All right. Other thoughts in response to the
6 guiding principles for measure selection? Anything else? Again, just -- I know
7 we are not looking at the slide but we had alignment, looking at reducing and
8 identifying disparities, feasibility around if essentially required data is available.
9 How the quality measures fit into California's priorities. We've got some more
10 hands up. I see, Bill, you have got your hand up.
11 MEMBER BARCELLONA: Okay, Bill Barcellona, America's
12 Physician Groups. Are you looking for a motion to adopt these guiding principles
13 that you have listed here today?
14 MS. BROOKS: So, great question. We are not looking for a
15 motion. I think what we are looking for is just some general consensus on these
16 are generally the guiding principles that should be utilized. But recognizing that
17 you all are also going to be bringing to the table your own expertise as we move
18 through this process and so not looking for motion.
19 MEMBER BARCELLONA: I think these are broad enough to
20 recommend.
21 MS. BROOKS: Thank you, Bill. Doreena.
22 MEMBER WONG: Hi, thank you, Doreena Wong from ARI. I just
23 was actually going to respond to Robyn's comment about the, you know, using
24 existing data. And it actually goes back to what Kiran was also asking about,
25 what data is available, so it would be helpful for us to know.

1 But I do believe that there is enrollment data on the, like for
2 Medi-Cal for disaggregated racial categories at least as well as for Covered
3 California, at least on the CalHEERS portal, they do collect disaggregated data.
4 Whether or not it is actually reported to the health plans as disaggregated data is
5 a question. But since it could, but I believe it could be shared with the health
6 plans and then once they have it then they could share it with providers.
7 At least so that looking at the sources of data and what we can do
8 in terms of trying to disaggregate it, I think, in requiring that data is a good, I
9 think, kind of basic fundamental starting point. I think, Anna, you kind of
10 recognized we can, we can determine or make recommendations about what
11 data should be collected and, you know, and try to move towards that. So that's
12 just an example I think of if we could get an idea of what data is out there and if it
13 is collected, if it is disaggregated, then that is a good starting point for us.
14 MS. BROOKS: So I think definitely a great point and we are going
15 to get into the data in a little bit here and talk a little bit about what is available
16 specific to California. But definitely a great point and we will get in there, thank
17 you so much. I see Kiran has her hand up.
18 MEMBER SAVAGE-SANGWAN: Thanks, Kiran Savage, CPEHN.
19 Can you just say a little bit more about number 6 and what is meant by California
20 priority area focus?
21 MS. BROOKS: I mean, I think that could be broad, right? So that
22 could be anywhere from if you are thinking on the Medi-Cal side, to be specific
23 CalAIM. It could also be specific to -- I think there's just kind of broad. There are
24 lots of conversations going on at the state level right now around diversity, health
25 equity and quality. And so the governor himself has prioritized that as an area for

1 focus and so I think just thinking about, you know, we heard from, I think it was
2 the first meeting we heard from the different departments about some of the work
3 and the priorities that they have been working on so that's more when we were
4 thinking about there. Silvia?
5 MEMBER YEE: Thank you. This is Silvia Yee with DREDF. I was
6 looking at the principles and had two specific questions. One was about 2b, the
7 potential for high population impact. I'm wondering, what was going into that?
8 Are you thinking about the numbers of people potentially affected or are you
9 looking at a sub-population and the potential improvement or not for that
10 particular sub-population? I was just wondering what was feeding into that?
11 And the second question is about feasibility, 4c, and the potential
12 for stratification. And also wondering what was going into that? That sufficient
13 numbers are being looked at or sufficient data is being gathered? I was thinking
14 about it in reference to what Rick was saying about bundling and wondering if, if
15 we are sort of trying to, I think it would require some tracing of the group that is
16 identified that actually gets screened. And then of that group who gets, who
17 actually gets some treatment. So you need to trace. And then the numbers get
18 smaller so does that affect how much you can stratify the results from something
19 like that. So those are just what I was wondering about. Thank you.
20 MS. BROOKS: Great questions. Some very technical. I think, with
21 respect to just your last question in terms of the denominator size, right. As you
22 get -- I think you need a denominator of 30, is that? Usually you need a
23 denominator of 30 to -- of a size that's -- a denominator that works. To your
24 point, yes, the number can get smaller and that would have some implications
25 but that doesn't mean that it is not important to look at the data. I don't know,

1 Andy, if you want to take, yeah, that would be great.

2 DR. BASKIN: So as far as impactful it can go, it can -- this is Andy
3 Baskin, I am sorry, Sellers Dorsey. It can go either way. I mean, generally,
4 impact can be impact on large populations. So for instance, diabetes is, you
5 know, 6 or 7 percent of the population, so if you can impact diabetes it is going to
6 have high impact even if it is only a little impact per person kind of thing or an
7 average.

8 But it can go the other way around. You can have smaller groups
9 for which the measure is focused on a smaller group of people. Like, for
10 instance, like rheumatoid arthritis, which is a much smaller population but could
11 have a very high impact on each one of those patients. So we want you to
12 consider both of those things. But certainly, one would, I think, agree, or most of
13 us would agree that if it is a very narrow population with a very low impact per
14 person that that's not going to meet the standard of one of the 10 or 12, or
15 whatever number of measures we come up with. You want each measure to
16 have the ability to have a reasonable amount of impact so it's more of a general
17 statement that way.

18 MR. BAU(?): So part of that is very similar to the stratification. You
19 are absolutely right. So some of the hospital measures, back to Ed, Ed's
20 comment, especially for smaller health plans, they just may not have that number
21 of hospitalizations to make the measure meaningful, even though it's really
22 impactful, it's really important. In other contexts, for example, there are often
23 measures related to the child welfare system and foster children might be one
24 example again. So really impactful, really important, but oftentimes by the time
25 you figure out how many foster kids have that particular condition the numbers

1 get smaller and smaller and it becomes a harder measure to sort of apply
2 statewide.
3 MS. BROOKS: Thank you. And thank you for your question,
4 Silvia. All right, Dannie, it looks like your hand is up.
5 MEMBER CESEÑA: Hi, my name is Dannie Ceseña, pronouns are
6 he/they. I am the Transgender Health Equity Manager for the California LGBTQ
7 Health and Human Services Network, which is a project of Health Access. I just
8 kind of wanted to build off of what Silvia was asking and as I have been listening
9 to folks with their questions and concerns. You know, when we are really
10 thinking about these measures and, you know, even measuring, you know, how
11 folks are getting screened, you know, for different co-morbidities such as
12 diabetes, breast cancer, chlamydia and such, is there going to be any type of
13 measurement regarding medication adherence? You know, we can get these
14 numbers back that's showing like, you know, yes, we are screening X amount of
15 people with a 90 percent rate of, you know, positive or negative. But, you know,
16 once folks are prescribed medication there's a lot of reasons for folks to not take
17 the medication and the biggest one being, you know, financial factor, you know.
18 It can still be out of cost range, you know, even if it's covered by insurance or
19 folks, you know, just can't afford it. And then we even have those who are
20 unhoused who might be, you know, diabetic and need to be on insulin but where
21 are they going to refrigerate it if they don't have a refrigerator due to being
22 unhoused?
23 So, you know, I think it's great that, you know, we want to measure,
24 you know, the different types of screenings, but what about the after and the
25 medication adherence? And I do know insurances do track the claims on that

1 because they have to pay it out to pharmacies so if, you know, if we are able to
2 track those claims and really start finding out and getting to the root cause of why
3 people are or are not taking their medication I think that is another health equity
4 principle that we need to keep in mind.
5 MS. BROOKS: Dannie, thank you so much for your comments.
6 Andy, did you have something?
7 DR. BASKIN: Yes. So it's Andy Baskin from Sellers Dorsey.
8 Dannie, thank you for that one. We will, we will take that as a suggestion to, as a
9 measure that we want to discuss in the chronic disease section because there
10 are adherence measures in existence. They didn't meet our initial criteria that we
11 will be getting into but we have we have always said that if there is a
12 recommendation by this Committee to talk about an additional measure we
13 would want to do that. So we will just put that on the docket for under chronic
14 disease, we will talk about medication adherence and measures as well. Thank
15 you.
16 MS. BROOKS: Perfect, Andy, thank you. And Dannie, great
17 comment, thank you so much. Let's see, Rick, it looks like your hand is up.
18 MEMBER RIGGS: Yeah, just a brief comment about the number
19 six that was called.
20 MS. BROOKS: Who are you, Rick?
21 MEMBER RIGGS: Oh, sorry, Rick Riggs. Sorry, Rick Riggs again.
22 So about the number 6 California area, priority area for focus, and the
23 opportunity for the measures that we do select to help satisfy AB 1204, which is
24 the requirement for -- that's coming up to include, among other things, an
25 analysis of health status access to care disparities, on the basis of specific

1 categories for health equity plans to reduce disparities. This is for folks that have
2 to file a, you know, community benefit plan, so all of those that are considered
3 not-for-profit. So I think we have the opportunity with these measures to help
4 guide how these not-for-profits may be reporting so I would just put that out there
5 as a connection point for other things that are in the environment that are
6 happening.
7 MS. BROOKS: All right, thank you, Rick. Other comments? Alice,
8 it looks like your hand is up.
9 MEMBER CHEN: Alice Chen, Covered California. I did walk back
10 as Ignatius was talking about stratification I believe in sample size and I just
11 wanted to share, and I apologize if you have heard this before I wasn't here the
12 first meeting, but I think one of my colleagues presented, but our experience at
13 Covered California has been that we tried to -- we had a set of 14 measures that
14 we wanted to stratify by race-ethnicity. And it turned out that many of them were
15 such infrequent events that when you started stratifying you just couldn't make
16 anything of the data. We then tried to bundle across lines of business and even
17 with that many of the measures, like avoidable ER visits or amputations, were too
18 rare to be able to do anything by stratification. And once we bundled across lines
19 of business there really weren't any benchmarks because every carrier had a
20 different payer mix. And so just wanted to share some of our challenges in terms
21 of as we look at the feasibility piece and potential for stratification, I think that's a
22 really important one, as we have the equity lens.
23 MS. BROOKS: Thank you, thank you, Alice. Kiran, I see your
24 hand is up.
25 MEMBER SAVAGE-SANGWAN: I just wanted to follow-up on that,

1 Alice. Like is that captured when you look at whether it has been identified as
2 disparity sensitive or sort of how will we know for some of them whether we are
3 going to run into that problem, I guess is my question.
4 MEMBER CHEN: I would look to my colleagues over here but I
5 would say like when you look across a given measure some of them are just
6 relatively infrequent events and I think there's a -- for us it was we learned the
7 hard way. I think you could eyeball it but there may be some more validated, you
8 know, statistical or quantitative methods to decide, but it's pretty clear when you
9 look at some of these measures.
10 MS. BROOKS: Ed, it looks like you have your hand up.
11 MEMBER JUHN: Thank you. Ed Juhn, Inland Empire Health Plan.
12 Is data sharing something that will be covered under number 6 as a California
13 priority area of focus or would data sharing fall under number 1, alignment with
14 other measurement and reporting programs?
15 MS. BROOKS: When you say data sharing you mean like on the
16 834 file specifically?
17 MEMBER JUHN: Or just in general when we are sharing data,
18 whether it's between plans or between health systems. Just the opportunity to
19 share potentially race, ethnicity, language data on members if they move
20 throughout the system, especially if we are thinking this through a five year glide
21 path.
22 MS. BROOKS: I would think that probably would fit more under
23 California's priorities given that there are differences in terms of alignment. But I
24 guess the thing that I would want to just make clear is that while very important,
25 that that's not part of the charge of the Committee specifically. And so important

1 issue to raise but just wanted to clarify that. Other questions or comments from
2 Committee Members? Shaini, do we have anybody from the public? All right.
3 Well, that was a really great discussion. Thank you to everyone for your input
4 and we look forward to furthering this discussion as we move forward.
5 All right, so we will move on to Slide 39. We are going to talk a little
6 bit about focus areas and disparities. And I am going to be calling in my lifelines
7 over to the left here, Andy Baskin and Ignatius Bau, so you will be hearing them
8 quite a bit as we move through here. All right, slide 40, please.
9 Okay. So, focus areas are over-arching themes of the measures
10 identified and are a way to stay organized throughout the process. So this is
11 really an approach to kind of organizing our process for like selecting the
12 measures as we talked about. And this is important, particularly given our limited
13 time to discuss candidate measures, select a measure set and benchmarks. So
14 as we heard earlier, sometimes some of these things can take years and we
15 have months and so we are looking at just having a process. We are looking at
16 ensuring that we have a process that will help guide us given the time that we
17 have, but also allow for good input from the Committee and make sure that we
18 get all of your recommendations to the DMHC.
19 So given the tight time line we just talked about for this Committee
20 we will want to consider established measures and benchmarks but are open to
21 further discussion on new measures as we talked about. So just having had a
22 discussion around that, you know, it sounds like there could be some time issues
23 established again.
24 So as measures are selected let's just keep in mind that some
25 measures could be considered for multiple focus areas so some candidate

1 measures could be moved to another focus area when deciding the final set as a
2 whole. So basically you will see as we pull up the slide, there are 12 different
3 focus areas. And we sent you the, we sent you five workbooks to focus on the
4 first kind of five different focus areas that we are going to attempt to talk about
5 today or we will get as far as we get today as we do. The point being that one
6 measure could fit into multiple focus areas, and so because it doesn't show up in
7 one focus area doesn't mean it's missing necessarily, it may be it is an another
8 focus area but we should just talk about that as we move through the process.
9 All right, next slide, please.
10 So as you will see when we get to the discussion of measure
11 section, we will discuss California-specific disparities throughout the discussion
12 of focus areas and measures for the Committee's consideration. Today we will
13 be specifically focusing on those five areas if we get through them which are
14 prevention, chronic conditions, behavioral -- excuse me, mental health,
15 substance use and mothers and children.
16 We are going to get as far as we get today so we are just going to
17 keep -- we are going to just keep talking about each of the areas until we have
18 gone through it and so I don't want people to feel rushed or like there is not an
19 opportunity to provide input into one section. If we don't get through one of those
20 it's okay, we will move it to the next. Next slide, please.
21 So here are the most common focus areas that I was just
22 mentioning. And we came up with these. We really did a scan of the most
23 common focus areas by utilizing national organization, state programs and best
24 practices. We looked at the CMS core set, NCQA, AHRQ, Medi-Cal, Covered
25 Cal and many of the different waiver demonstration programs across the nation

1 to kind of gather these different focus areas that we have pulled together here.
2 So you can see that the scan resulted in 12 areas, as I mentioned, for
3 consideration by the Committee.
4 However, there are other focus areas Committee Members may
5 want to consider and so, you know, we definitely welcome that input and would
6 like to talk about that but would ask that if you do identify another focus area that
7 you think might potentially need to be added that maybe you offer a measure that
8 might fall under that focus area so we can better understand it and make sure
9 that it -- and see how it aligns and fits with the rest of these. And make sure that
10 potentially that measure might not just fall under another focus area potentially.
11 So let's see. The focus areas, we sent out in advance of this
12 meeting and it is posted online, a document called the Focus Areas Reference
13 and Resource Document. This document included examples of the different
14 types of measures. In the reference document the measures highlighted are just
15 really for the sole purpose of Committee review, not intended to be suggestive as
16 measures for the Committee to consider, just examples. So just wanted to make
17 that clear to you all. All right, next slide, please.
18 So these are some of the questions that we have come up with to
19 kind of drive today's conversation but welcome any other feedback or response
20 to other questions as well. Do you have questions about the focus areas or need
21 further clarification? Would you like to add to the list of focus areas provided?
22 And then, if there are additional focus areas you would like to see, can you
23 please provide an example of an existing or a suggestion for a new measure for
24 that focus area?
25 So, I am going to -- is it. So everyone has got the slides, you can

1 look at what the focus areas are, we will leave the questions up for discussion.
2 So let's open this up and just see what are people's thoughts about the focus
3 areas that are included on this list?
4 MEMBER BARCELLONA: I can't, sorry, I can't get my computer to
5 raise its hand.
6 MS. BROOKS: So Bill is, Bill is raising his hand in the room.
7 MEMBER BARCELLONA: Okay. So Bill Barcelona, APG. So
8 quick question. You have got 12 focus areas? What is the total number of
9 metrics? What is the total number of metrics that we are looking at adopting at
10 the end of this process?
11 MS. BROOKS: Okay. So ultimately this is up to the Committee to
12 make recommendations to the DMHC with respect to the number of metrics. We
13 would share with you that generally 10 to 12 metrics is what would be adopted
14 and be feasible for health plans to kind of have enough opportunity to focus. You
15 have heard from Covered Cal today, other perspective in terms of the number of
16 measures and their experience as well. So that's kind of the general answer that
17 I would give to you but I think the Committee is making the recommendations
18 here.
19 MEMBER BARCELLONA: Right, okay. So that is my familiarity
20 with the number of metrics as well. And I am looking at 12 focus areas here, 12
21 domains, which would lead us to adopt several dozen metrics if we focus on that
22 many domains. At APG, we have a standards of excellence program that we
23 have used for about 15 years and we have seven domains and we have dozens
24 and dozens of specific metrics that fall into those domains. So when you -- I just
25 want to caution that when you take this approach around a domain approach you

1 end up with a lot of metrics, okay.

2 MS. BROOKS: I think just to make a comment in response to that

3 and I see Andy up over here. You're right, in totality there are like 800 measures

4 or something that we have seen so far. We are not going to look at 800

5 measures in here, I don't think people want to do that. Is that a fair assumption?

6 But the intent is to use these focus areas to narrow -- and then the guiding

7 principles to kind of narrow the measure so that there could be anywhere from

8 like zero, there could be zero, we might not identify any measure for one of these

9 focus areas potentially, or we might identify four or two to three. So really, it just,

10 you know, it will happen through the discussion.

11 The workbooks that we provided to you, you will see that there are

12 two tabs, one has like all of the measures for the specific focus area and then the

13 other tab in that workbook has those that kind of follow these different guiding

14 principles. So that narrows the number down to your point, Bill. But then also to

15 Andy's point earlier. We welcome adding a measure like Dannie added earlier

16 and look forward to having that discussion. Did I say anything wrong, Andy?

17 DR. BASKIN: No, you did not. It's Andy Baskin again. No, you did

18 not, you said wonderful things. But I did want to, I did want to just reiterate a

19 couple of things. The purpose of having 12 focus areas is so that we make sure

20 we talk about a broad swath of measures over a wide variety of topics. This by

21 no means is making a recommendation that you have a measure in every one of

22 those areas; certainly that is going to be up to the Committee.

23 And as you stated, if we are looking for 10 to 12 or maybe it's,

24 maybe it is 6 to 18 or whatever we turn out to be, there will presumably be some

25 areas we won't have a measure or some that they have two because they are

1 more important and they are broader. And some of these are broader areas than
2 others anyway so they are more amenable to more than one measure.
3 But it was also to make sure that no measure that is of interest
4 doesn't get discussed. So let's make sure that, you know, you may not want a
5 utilization measure but we should talk about utilization measures if somebody
6 has a concern about utilization measures. I mean, I think that's one of the
7 examples. So it's not prescribing a number of end measures by any means.
8 MS. BROOKS: And then, you know, the one other comment I
9 would just make is on the health equity because this came up last time. So,
10 health equity kind of plays two roles here, and Ignatius come in and just correct
11 me here. But it obviously is infused throughout, right. But as well health equity
12 stands on its own it that there could be things like structural type of measures
13 that are health equity-specific, so collecting demographic data, looking at cultural
14 and linguistic appropriateness of services, interpreters, and so on. So that's
15 really why we included it as its own stand-alone there as well as it kind of is built
16 into the rest. So just wanted to kind of touch on that. And Ignatius, I don't know
17 if you would add to that?
18 MR. BAU: And the only thing I would add is, again, just because
19 this is an organizational framework, we may decide that none of those measures
20 are ones that the Committee would recommend and that we will just do
21 stratification as a health equity strategy throughout, or we want both stratification
22 as well as some specific health equity measures. Those might be measures that
23 are less in use because health equity isn't a pervasive topic in a lot of measure
24 sets and so this may be where California is pushing the envelope a little bit. So
25 again, that's all for the Committee and we are just doing this, again, purely for the

1 organizational structure.

2 MS. BROOKS: Rick, I see your hand is up.

3 MEMBER RIGGS: Yes, thank you. This is Rick Riggs. Thank you

4 for the health equity sort of descriptor there because I sort of saw that one in

5 population health as being very, very large and unwieldy.

6 And then the piece around the tension between access and

7 utilization. Some of the focus groups that we have done in our area have, have

8 eliminated for us that just because people have access, meaning they have

9 coverage or they have an assigned PCP or other pieces, that they may still not

10 know how to get to utilization. And so I just think there's a tension there. I am

11 just pointing it out. I don't have any solutions or measures but I do think it is

12 something that if we are talking about health, health care disparities, that we

13 have to just know that it's there.

14 MS. BROOKS: Thank you, Rick. Diana, I see your hand is raised.

15 MEMBER DOUGLAS: Thank you. Diana Douglas with Health

16 Access. I think just a couple of points to make to the comments on the number

17 of focus areas and the potential for number of measures associated with each. I

18 think given the goal of trying to narrow down to a small set of measures I just

19 encourage us to think about which measures can cut across multiple of the focus

20 areas and not to think too rigidly about the focus areas necessarily as we talk

21 about measures and to look for opportunities to capture multiple. I think that is

22 possible with all the great measures that there are to select from.

23 And then again I think as we are looking at measures to do so with

24 the time line in mind that we are determining these, they will be around for a

25 number of years. We know that California often leads the way in our innovations,

1 and you know, what we are trying to get out of our care delivery system. So I
2 think as we look at measures we should also consider not just which may be
3 beneficial to us now but which will best be able to capture improvements and
4 innovations both with the science of health care, the delivery of health care over
5 time as well.
6 And can I clarify? I see the ones that are asterisked for today. Will
7 the others be up in a subsequent Committee meeting?
8 MS. BROOKS: Yes. We will get through as much as we get
9 through today on the five that we have and then the next meeting we will
10 continue the discussion. We will touch on each of these different focus areas.
11 MEMBER DOUGLAS: Thank you.
12 MS. BROOKS: Other questions or comments? Shaini, anybody in
13 the public? Alice? Since you are on the Committee go ahead, Alice.
14 MEMBER CHEN: Alice Chen, clearly not dealing with the
15 protocols, from Covered California. Diana's comment just made me reflect back
16 on some of our guiding principles. Not to go backwards but just to reflect on the
17 fact that if the goal of this entire exercise is to improve the health of Californians
18 you may want to at some point think about, again, not just the feasibility of data
19 collection but feasibility of the health care system and health plans actually
20 moving the dial on that measurement outcome.
21 And that does kind of tie back to, I think Diana's point is really well
22 taken that we want to look forward. And at the same time when I think about
23 where we are now and how little progress we have made in the last certainly 10 if
24 not 20 years in terms of chronic conditions, some of the very basic conditions, I
25 do wonder if that looking forward entails a little bit looking back and landing on

1 those things that we know are really important and we know the measures. A
2 drive towards action that will improve care and use that as an organizing
3 framework or selection criteria.
4 MS. BROOKS: Thank you, Alice. All right. So we will move to the
5 public comment, Shaini. Oh, Shaini, I apologize, I'm sorry. Go ahead, Rhonda.
6 Go ahead, Andy.
7 DR. BASKIN: So it's Andy Baskin. We asked the same question
8 internally, it is a good question. Actually, within the focus areas when we start
9 talking about measures we will be grouping them. So for instance, when we get
10 to mothers and children we will probably talk about mother measures, you know,
11 women's health measures separately than in children's measures so we are sort
12 of within the group. When we get to chronic diseases we will presumably talk
13 about diabetes separately from asthma so the same sorts of things will happen in
14 many of, many of these focus areas. But you will see how we, how we work
15 through it the first couple of times.
16 MS. BROOKS: I think we intentionally picked prevention as the first
17 focus area for today, because we thought it would help us kind of get into the
18 groove of how we are going to go through each of these different (inaudible). All
19 right, any other questions, comments, feedback in the room from the Committee
20 Members or online?
21 So now we will move to public comment, thank you.
22 Hello?
23 MS. BROOKS: Hello. We can here hear you if you would like to go
24 ahead with your comment.
25 MR. NORIEGA (other speakers heard in background): Thank you.

1 Allen here with CBO Illumination Foundation. I just wanted to confirm where that
2 reference sheet that was mentioned earlier with the focus areas, it was
3 mentioned before it went on. Does it go a little bit more in depth?
4 MS. BROOKS: Yes. So all of the materials for today's meeting are
5 posted on the DMHC website. There is, we have that information in the
6 PowerPoint as well, is that right, Alex? We have contact information in the
7 PowerPoint. If you have any questions please feel free to reach out to us and we
8 are happy to share information with you.
9 MR. NORIEGA: Okay, and then one last thing. There was mention
10 that there was a -- I forgot who was the one that mentioned it,but there's a
11 tension as far as actual use of the insurance or people's use of insurance. I was
12 wondering if that went anywhere or if that will be included next time?
13 MS. WATANABE: It was the question about whether or not we are
14 going to include access or utilization, like people have coverage but they don't
15 know how to use it.
16 MS. BROOKS: I see, I see. I think it was Rick's comment. Sorry.
17 MS. WATANABE: Yes. And if I could just for those that are joining
18 remotely, if you go to the DMHC's website at healthhelp.ca.gov, which is shown
19 here at the bottom of the screen, on our home page under What's New you will
20 see a link to our Health Equity Committee and all of the documents for this
21 meeting should be listed there.
22 MS. BROOKS: Thanks, Mary. So I think in response to your
23 question and Rick's comment earlier about kind of health -- or access and
24 utilization and how they kind of work together. We will be discussing each of
25 those different focus areas. We will be talking about the different measures that

1 fall underneath each and those that may fall under both so there will be some
2 discussion there.
3 With respect to kind of diving into the overall larger policy issue,
4 that likely is not under the charge of this Committee and so we will have some
5 discussion on it but it will be limited to kind of the focus areas and the metrics
6 that we will be discussing.
7 MR. NORIEGA: Thank you so much.
8 MS. BROOKS: Thank you. All right. So it sounds like no other
9 public comments so we will move on. Oh, wait. Sorry, never mind. Kiran, you
10 have a comment? Sorry, about that.
11 MEMBER SAVAGE-SANGWAN: Totally out of order. I am not
12 sure if this is going to be, like these focus areas are going to be part of any kind
13 of, you know, public presentation of the end product or anything. But just on
14 Mothers and Children, from looking through the measures that are included in the
15 handout, we are really talking about people who are giving birth, right, and so we
16 may just want to say that. I think in the reproductive justice movement there's
17 been sort of a move towards saying birthing people instead of mothers so that's
18 just a terminology thing.
19 MS. BROOKS: Okay. That's helpful, thank you, Kiran. All right,
20 taking note of that.
21 MEMBER SMITH: To hear from the gentleman who spoke earlier.
22 If he wants to have the community perspective reflected in this, if there is
23 anything that he would like to add or think, what he thinks about these focus
24 areas.
25 MS. BROOKS: Sure, yes. Would either of you like to make a

1 comment in response to the focus areas?

2 REV. SHORTY: When you -- Reverend Mac Shorty, Los Angeles; I

3 am the founder of Community Repower Movement, which is an engagement

4 nonprofit.

5 When you looked at some of the areas, prevention, mothers and

6 children, chronic conditions, mental health and substance use. Mothers and

7 children is already being addressed by First Five Los Angeles or First Five LA in

8 underserved communities. We have -- LA County is spending millions of dollars

9 on mental health down in LA County and also on substance abuse use. They

10 are great areas to look at but when it comes to really being more of a focus, I

11 mean, there should be other areas added also.

12 One of the gentlemen spoke about utilization. And patient

13 experience is important. I was sick twice in the hospital with COVID. Like

14 anybody else I wanted to get out. It took the nurses three hours to bring me a

15 cup of water. I have high blood pressure. My mouth was drying up. But the only

16 people who wanted to work at this time during COVID were older, older people.

17 The younger people sat at home collecting unemployment, it was shameful.

18 Here I was. Dr. Brooks said if I hadn't took my first COVID shot that I wouldn't be

19 here speaking because I would have ended up on a ventilator because of the

20 obesity, the high blood pressure, the COPD and the other underlying conditions.

21 So, I mean, it was a scary moment in life to be facing as a 53 year old young

22 man.

23 And when you look at it, in our country we are so used to seeing a

24 lot of older people passing. But now when you look at the rate the older people

25 are outliving the younger people. The younger people, I don't get it. I don't know

1 if it's something in the water or they're drinking too much Kool-Aid, but when it
2 comes to health care it's like getting a new iPhone is more important than health
3 care. Following the latest game trend is more important than health care. And
4 we try and do community engagement to make sure people understand how
5 important health care is. You know, there's places people would die for decent
6 health care. They would literally sell their children, cut off an arm, sell a liver, sell
7 something just so that they can have decent health care.
8 Here, we live in a country, I don't know if we are not doing our job
9 as leaders by not engaging these people. I mean, I've got a son with two college
10 degrees who wouldn't even take a COVID shot. Educated. Then he gets mad
11 because I tell him he is an educated fool. Your dad was in the hospital a week
12 on oxygen, almost dying. Here my son living at my home, refused to take a
13 COVID shot. And he has two college degrees. Educated, young, healthy. Their
14 mind-set, our country's mind-set when it comes to health care, it really needs to
15 be changed here in California. Because if we don't change it what is going to be
16 left? There is no future.
17 MEMBER SMITH: Sorry, sorry, sorry. I don't know. So I was just
18 saying the important word he said was COVID. And when we talk about or think
19 about immunizations or vaccinations, would that be something that would fall
20 under the category of prevention? Because, you know, it is something that is not
21 going away anytime soon so something we need to consider as part of
22 prevention and wellness, I guess.
23 MS. BROOKS: Yes. So I think that Andy is looking for --
24 DR. BASKIN: Andy Baskin. Yes; yes and no. I mean, all
25 measures can be talked about, of course. Immunizations or general population

1 immunizations like COVID or the flu would fit under prevention. We did put
2 childhood immunization measures under the child ones so that immunizations
3 could get talked about in two different places. So I just wanted to point that out
4 just to make sure people understand that because it's kind of fit with the other
5 child measures in terms of access to care and whether they have made their
6 visits and things like that. So if your sense. But by all means we once again take
7 that as we should add that to the top of when we get to prevention because it will
8 be the first topic. Thank you.
9 MS. BROOKS: I think Alice, you have your hand raised.
10 MEMBER CHEN: Alice Chen, Covered California. And Rhonda,
11 your point and the Reverend's point makes me wonder if another potential
12 principle would be kind of impact of COVID-19, not just on the vaccinations but
13 there are a number of these measures that actually have gotten significantly
14 worse as a result of COVID, whether it is childhood vaccinations or blood
15 pressure control or diabetes. I mean, I think that could be another lens in terms
16 of the -- and there are clear racial and ethnic disparities within that COVID-19
17 impact.
18 MS. BROOKS: Any other comments or feedback? Silvia, it looks
19 like your hand is up.
20 MEMBER YEE: I think this is brief. I was listening to the Reverend
21 and thinking that another underlying theme he is getting at is communication.
22 The effective communication, which has multiple kinds of barriers. I mean, we
23 often think of language. There's health literacy and so forth. But there's also
24 kind of reaching, reaching people to help them understand the importance of
25 health insurance, health coverage and so forth. And I wasn't quite sure. I mean,

1 I looked at the focus areas and I can see them falling potentially under a number
2 of them so maybe we will just address them in a number of these areas. But I
3 mean, it does see -- it affects health equity obviously, access utilization. So I just
4 wanted to raise that because that's what I heard from what you were sharing.
5 Thank you.
6 MS. BROOKS: Sorry, I have a little tickle in my throat. Great
7 comments, Silvia. Definitely something that we can incorporate as we move
8 forward similar to other components of the discussion. Doreena, it looks like your
9 hand is up.
10 MEMBER WONG: Just listening to Silvia just prompted me and
11 then responding to the Reverend also. I guess it also made me think of like more
12 of the social determinants of health. And I don't know if that goes into health
13 equity or where that would go but maybe some kind of measure. I am not sure
14 even how to measure that but just for us to consider how the social determinants
15 of health, a much broader view of health would be something to think about.
16 MS. BROOKS: Certainly. This has been a great discussion, lots of
17 good input and comments, appreciate everybody. Anything else that anyone
18 would like to contribute? We are going to take a quick break after -- that wasn't
19 a, I wasn't trying to end the conversation there. Any final comments though? All
20 right. So we are going to take a 10 minute break. We will come back at 3:15 for
21 those of the you that are online or in the room and we will see you in just a few.
22 (Off the record at 3:04 p.m.)
23 (On the record at 3:18 p.m.)
24 MS. BROOKS: We will begin our discussion on measures now. So
25 as I mentioned earlier, we are going to use the focus areas as a way to organize

1 the conversation around the identified measures so this begins our conversation
2 and our dive into that area. Next slide.
3 Okay. So to begin, the process for selecting measures, I will just --
4 okay. We used the *Buying Value* tool kit resource that was created by the Robert
5 Wood Johnson Foundation and that, as I mentioned earlier, lists 800 or over 800
6 measures to assist state agencies, private purchasers and other stakeholders in
7 creating quality measure sets.
8 So from there we took the 800 measures, or 800-plus measures,
9 and organized those measures by focus area; and narrowed the list to measures
10 that aligned with DHCS, Covered California and IHA, or that are widely used in
11 federal programs. So you will see in the workbooks when you look at them that
12 these are the green measures in each of the workbooks included in your meeting
13 materials. Green measures are those where the cell is filled in with green, that
14 seems obvious but I am just going to say it, in column A in your workbooks. So,
15 hopefully that helps give you some guidance.
16 As previously described, we have identified measures by focus
17 areas that align with the different areas, Covered California, DHCS as I
18 mentioned, IHA and other federal programs.
19 So throughout this discussion when we review the measures
20 please refer to the respective Excel workbook in your meeting materials. For
21 those that are online, those workbooks are available on the DMHC website and
22 you can go to health help.ca.gov to find that information.
23 Based on the Committee feedback in the workbooks we have
24 included if the measure is a designated NQF disparity sensitive measure, if it is
25 risk adjusted, and if there is existing performance data for the Committee's

1 consideration. As a reminder, the disparity sensitive measure status is based on
2 NQF's designation and refers to measures that detect not only differences in
3 quality across institutions or in relationship to certain benchmarks, but also
4 differences in quality among populations or social groupings. So for example,
5 race, ethnicity, language, and so on.
6 So throughout each focus area we will walk through these
7 measures but welcome the Committee to propose other measures from the
8 workbook or suggest new measures to create. So as I mentioned earlier, there
9 are two tabs in each workbook. One has the narrowed set, which has the green
10 in the column A, and then there are all the other measures for that specific focus
11 area on the other tab. We welcome you to look at those and make any
12 recommendations for consideration. Not narrowing and excluding anything here.
13 All right, so next slide, please.
14 As measures are presented for consideration it is important that the
15 Committee keep in mind the specific disparities that exist in California. CHCF or
16 the California Health Care Foundation disparities report in combination with the
17 Commonwealth Fund Health Equity Scorecard present key findings on areas of
18 inequities throughout the health care system. To walk through, excuse me. To
19 walk through the California-specific prevention disparities I am going to pass it
20 over to Ignatius who is going to talk a little bit about those now.
21 MR. BAU: Great. So Ignatius Bau; thanks, Sarah.
22 So again, for the Committee, we could have drawn the disparities
23 data from lots of different sources so I just as a shorthand use these primary two
24 sources from the California Health Care Foundation and from the Commonwealth
25 Fund. And then I also want to caveat, even though both of them were published

1 last year, which is fairly recent and that is good, some of the specific data on the
2 specific points that they have in those reports are actually much older, go back
3 as far as 2015, so it is not necessarily all 2021 data.
4 Again, we want to emphasize that these are not the exclusive
5 sources of data around disparities and we really invite and welcome and
6 encourage Committee Members to also raise data points that they know of where
7 there's disparities of particular issues and concerns for them. But again, just as a
8 way to ground us in this conversation and keep disparities front and center as
9 much as possible we are just illustrating some of the disparities that are out
10 there. They are going to be different primarily across race and ethnicity for the
11 different types of conditions.
12 And the last thing I will say is, unfortunately, there is not a one-to-
13 one correspondence so that if there's disparities in diabetes, that if the
14 Committee recommends a particular diabetes measure, doesn't necessarily
15 guarantee that the disparities gets reduced. But it would at least get us towards
16 starting to understand better whether those disparities are persisting or whether
17 they are decreasing over time, especially over the five year time line that these
18 measures would be used.
19 So as an example, to start on this slide, slide 47. We know that the
20 rate of just having a basic checkup varies across Californians depending on their
21 race and ethnicity. That American Indian, Alaska Native, Native Hawaiian and
22 Pacific Islander Californians were much less likely to have a checkup. Next slide.
23 We know in terms of breast cancer that the highest death rate from
24 breast cancer are among Black and white Californians.
25 The lowest rate of cervical cancer screening is among Asian

1 persons.
2 The lowest rate of colorectal cancer screening are among Latinx
3 and multiracial Californians. Next slide.
4 And then there's both -- again, we talked a little bit earlier about
5 screening versus outcomes. And so while the rate of breast cancer mortality is
6 highest among Black and white Californians, the lowest rate of screening is
7 among American Indian/Alaska Natives and so again there's disparities both on
8 the screening side as well as on the outcome side.
9 The highest death rate from colorectal cancer are among Black
10 Californians.
11 And the higher, there is a higher smoking rate among Black and
12 American Indian/Alaska Native Californians.
13 So again, just a snapshot of different types of disparities so that
14 when we go to the next slide, slide 50, these are the measures that we are
15 elevating for consideration because they are used in other programs. So there is
16 a cervical cancer screening measure, a chlamydia screening measure, a breast
17 cancer screening measure, a colorectal cancer screening measure, and then
18 medical assistance with smoking and tobacco use.
19 As Sarah noted, the National Quality Forum has designated certain
20 measures as disparities-sensitive. That over time that they can see that there
21 are disparities among those measures and so that's another data point for you all
22 to consider, that the first four are designated as disparities-sensitive.
23 And then the colorectal cancer screening measure is one that the
24 National Committee for Quality Assurance will be requiring stratification by race
25 and ethnicity starting this measurement year.

1 And the breast cancer screening measure with the two asterisks is
2 a candidate that NCQA, National Committee for Quality Assurance, is
3 considering whether to require stratification by race and ethnicity starting next
4 year.
5 And so again, for the purposes of future benchmarking and ease
6 and feasibility of stratification those are also considerations for you. Again, we
7 are leaning heavily on this notion of alignment with what other state and national
8 programs might be doing. So we open it up for the Committee.
9 DR. BASKIN: Sarah, just some comments to add on to -- Andy
10 Baskin. I had some comments to add on to Ignatius, what he just said. A couple
11 of things. One is just because once again Ignatius didn't note that it is one of
12 these, in one of these reports that there's disparity doesn't mean a disparity
13 doesn't exist, okay? So nobody is claiming that medical assistance with smoking
14 and tobacco use doesn't have disparities. In fact, very likely any measure we
15 have there will be some disparities depending on how you look at the different
16 stratified groups. We are just saying that there's some general information that
17 we have looked at that sort of point to a couple of other measures. By no means
18 is it to eliminate a measure.
19 And I also wanted to point out that just remember that we have kind
20 of added adult immunizations already to this list to talk about as well and of
21 course welcome additional suggestions as we have the conversation. Thank
22 you.
23 MS. BROOKS: Thank you, Andy and Ignatius.
24 So I think everyone is clear. I won't go through the directions again
25 in terms of how to look at the workbook but if you have questions just please let

1 me know. We will open it up. And as I should have mentioned, this is obviously
2 the discussion on our first focus area, which is prevention. And as I mentioned,
3 we thought this would be a good focus area to really allow us to kind of get
4 familiar, familiarized and move forward.
5 So for Committee discussion, are there any other measures you
6 feel strongly should be added or created to the list of candidate measures?
7 And at this time, which two to three candidate measures from this
8 focus area should be considered for the final set?
9 So I will open it up and see what -- oh, there's already hands up,
10 look at that, okay, all right. Rhonda, we will start with you.
11 MEMBER SMITH: Okay. Rhonda Smith, the
12 California Black Health Network. I was just curious about, it is interesting that
13 prostate cancer is not on here so I just wanted to get your input on, you know,
14 the reason why or what you are seeing in terms of data.
15 DR. BASKIN: I don't have any disparities data for you, if that is
16 what you are asking, but the reason it did not get on this is because none of the
17 major programs that we looked at had selected prostate cancer as a -- or
18 prostate cancer screening. And just as a clinician, since I happen to be a doctor,
19 part of it is the recommendations around the screening for prostate cancer are
20 not as cut and dry as the recommendations for some of these other screenings.
21 The recommendation is actually, you know, discuss it with your doctor as to
22 whether it's necessary or not> It is not a clear cut everybody at this age should
23 get, everybody at this age should not, so it is a more difficult one to, to create a
24 measure on.
25 MEMBER SMITH: Yeah, I mean, just from a disparity standpoint, I

1 mean, we know that, at least from a screening and behavior standpoint, that
2 African American men or Black men are less likely to get screened but also there
3 are disparities there when we talk about, you know, death and survival rate.
4 And then also I think we are seeing from a colorectal cancer
5 screening standpoint, I know what the guidelines are, but we are seeing more
6 and more younger people being diagnosed with colorectal cancer too. So I don't
7 know how to address that in, in these measures, but I think it's something to
8 consider. And I could say the same thing for breast cancer too, especially when
9 we talk about triple negatives, so. To your point, they are not so cut and dry,
10 right?
11 MS. BROOKS: Great comments, Rhonda. All right, Bill.
12 MEMBER BARCELLONA: Okay. So Andy and Ignatius, we're
13 thinking about disparities in maternal mortality.
14 MS. BROOKS: Yes, thank you for bringing that up.
15 Bill, can you introduce yourself and who you are with?
16 MEMBER BARCELLONA: Oh, Bill, I thought you did that, sorry.
17 MS. BROOKS: You raised your hand.
18 MEMBER BARCELLONA: Bill Barcellona, APG, chronic non-hand-
19 raiser.
20 MR. BAU: So the maternal measures are in the people who give
21 birth and children. So you can move a maternal measure here if you want. But
22 again, just for organizational purposes, that's --
23 SPEAKER: These are mostly at prevention and screening kind of
24 things, right? That's all right. But good point. Yeah.
25 MS. BROOKS: So we will come back. We will circle back when we

1 get there, Kiran. All right, Kiran.

2 MEMBER SAVAGE-SANGWAN: Sorry, Kiran Savage, CPEHN.

3 Just a process question. So when we talk about an ultimate measure set with

4 maybe 10 to 12 measures. I just want to understand, do we at some point need

5 to say, you know, for breast cancer screening, the target is going to be to

6 increase the screening rate for this population, versus somewhere it might be this

7 screening rate for everybody. Like at what point does that become part of the

8 measure set or how do we determine which are the specific changes or

9 improvements that plans will be held accountable to?

10 MS. BROOKS: I think there's two pieces and then I will ask others

11 if they have comments. You know, the first is that we are looking to use the

12 current technical specification for each measure. I think that it becomes more

13 complicated for providers. We hear from providers sometimes that when you

14 change the technical specifications then they are reporting on the same measure

15 in multiple ways and it can be administratively burdensome, so that's one reason

16 to consider that. But on the flip side, if there were something that you wanted to

17 tweak or make a change to that could be a discussion that we could have about

18 a recommendation for a different kind of a measurement, if that makes sense.

19 But let me see if Ignatius, Andy have any additional?

20 DR. BASKIN: Yes, it's Andy Baskin. So I think there's a bunch of

21 possibilities when we start talking about benchmarking and where we want the

22 performance to go. Unfortunately, there's not a lot of baseline numbers. For

23 some of these measures. Let's say breast cancer screening is one of the ones

24 that NCQA is just asking for and I guess the first measurement year was 2022, I

25 think, or was it 2021 reported in 2022? But anyway, the first year's data will get

1 out there so it's going to be really hard to talk about how we would benchmark
2 and stratify numbers.
3 But I think at the end of the day, we can make a recommendation
4 that the total breast screening number, aggregate number for all populations, we
5 would make a recommendation of where we think that should go. But you can
6 additionally make a recommendation to say that we want to close the gap
7 between -- and you'd have to pick two populations to close the gap on because I
8 don't know how else to measure closing the gap. So you'd have to say, you
9 know, between the, you know, the white population and the African American
10 population if they are two of the stratifications that we have available to us or
11 whatever they are. And we could make a recommendation about how much to
12 close a gap versus a performance measure of a general number across the
13 measure.
14 I think it is a little premature to do that. We will be looking at as
15 much specific data as we can when we get to the benchmarking part of this,
16 which will be in a couple of meetings from now. But we will be limited by what we
17 have available in terms of what the difference is on the stratification piece. Does
18 that make sense to you?
19 MEMBER SAVAGE-SANGWAN: Yes, that makes sense. So in
20 terms of process what you want to do right now is have us provide input on the
21 two or three that we generally think are important with this data in mind and then
22 we are going to come back to talk at some later date.
23 MS. BROOKS: Correct.
24 MEMBER SAVAGE-SANGWAN: Talking about what the
25 benchmarks and targets actually are and which ones we are really looking at

1 reducing disparities and that's where there will be -- I am concerned about
2 making sure that we actually, that the Department is able to do their enforcement
3 around specific disparities reduction goals, I guess, is what -- I am just trying to
4 make sure we don't miss that.
5 DR. BASKIN: But also just to reiterate, Andy Baskin, that when we
6 say, you know, the two or three best, as you mention, we think are maybe the
7 best choices out of this group, this is not the decision of whether it makes the
8 final list. All we are doing is saying, let's move those forward. We are going to
9 have a chance to discuss them again and at some point, we are going to have to
10 take whatever we say out of each of these groups is the best candidate and
11 decide which of those are the final recommendation. That will be up to the
12 group.
13 MS. BROOKS: Thank you, Andy. And does that clarify, Kiran, your
14 question?
15 MEMBER SAVAGE-SANGWAN: (Inaudible.)
16 MS. BROOKS: All right. Doreena, it looks like you are up.
17 MEMBER WONG: Yes, thank you, Doreena Wong from ARI. I
18 was wondering, is this now the time. I hate to sound like, you know, being
19 repetitious, but isn't this now the time when we now can talk about data
20 disaggregation. Because I think when you are talking about the specific
21 disparities like this, this is when certain subpopulations will have different
22 disparities. And it would impact, it could impact, you know, the measure that we
23 might want to select.
24 So I am just wondering, you know, do we talk about that now and
25 say, and try to propose, I don't know, there's other data sets I think that we might

1 be able to look at that I am sure Andy and Ignatius are aware of. Like for
2 California data, just in terms of identifying disparities, perhaps like the CHIS data,
3 the California Health Interview Survey.
4 And then, and then even, you know, the Office of Minority Health
5 uses different categories, disaggregated data categories. For ethnicity they have
6 like four categories. For the Asian population they have seven and for the Native
7 Hawaiian/Pacific Islander population they have four. So there, you know, there
8 just are other data sources we could look at to try to find, at least, at least to see
9 if we are talking about trying to identify disparities, trying to find out, you know,
10 what the difference might be when you disaggregate the data. So I would kind of
11 appreciate the, you know, research into that.
12 MS. BROOKS: So definitely now is, now and throughout these
13 discussions is the time to be bringing up those different kinds of comments that
14 you just made. So with respect to disparities that we may know, may have -- that
15 may have been identified that you may have knowledge of or other sets of data,
16 things that we need to consider or look at, yes, please raise those, that's the
17 intent of the discussion. So appreciate you kind of calling out Office of Minority
18 Health and CHIS. I don't know, Ignatius, if you have any comments.
19 MR. BAU: So this is Ignatius Bau. So in response to Doreena's
20 comment, yes. So we know, for example, the lower rate of cervical cancer
21 screening among Asian Californians is primarily driven by the low rate among
22 Vietnamese women. And there's, again, a larger population of Vietnamese
23 women compared to other states and so that may not show up in national data or
24 other kind of state data.
25 So again, I am not sure that that's going to help move the

1 conversation because we have already identified that that's a place where there
2 are disparities and so, again, I am not sure we are going to be able, with 10 to 12
3 measures, craft measures that are specific to every sub-population. We want to
4 move the health overall of California and we want to reduce disparities. And so
5 considering that might be an important issue, for example, in the Vietnamese
6 community, would be important to consider but it is not going to be driving a sole
7 decision point.

8 MEMBER WONG: Yes, Doreena Wong again. Yeah, I appreciate
9 that it may not, well, it may or may not affect, you know. We may or may not be
10 able to craft a measure to capture the impact on certain subpopulations but it
11 may, it may at least help us. If you were trying to look at outcomes we may be
12 able to see, I don't know if it would help identify targets or goals. But anyway, I
13 guess we can think about that. Thank you.

14 MS. BROOKS: Thanks, Doreena. Bihu.

15 MEMBER SANDHIR: Hi, Bihu Sandhir from AltaMed. I actually
16 want to piggyback on what Doreena just said. I think right now I really appreciate
17 actually how you have separated these out and you have done all the preliminary
18 work so you have taken out a lot of the part, you know, about the disparities. But
19 this to me is not enough information to make an educated decision of which ones
20 to move up.

21 And so what we are -- so one thing to think about is, I think we have
22 had these conversations already, is the domains. How many domains does it
23 actually hit, each one of these measures? I think that would be helpful to us. And
24 what is the real impact? And I think that we could have that kind of data. So
25 what is the population? How much is -- how many numbers of people is this

1 going to affect? Because if it is only going to be 1,000 then it is not really as, you
2 know, as maybe -- I am not saying it is not important but I think from this
3 Committee the impact will be so much more if it is more than, you know. The
4 most impact, the population that is most impacted by it. So I think that's
5 important to share with us before we can actually make that decision. At least in
6 my case I feel that that would be helpful.
7 The other part that I, and I actually think this was a good point
8 about like just talking about colorectal cancer. So the US Preventive Services
9 Task Force just updated their -- this is how what we -- the impact is for us in real,
10 you know, like when we were practicing. So the impact was last year in May is
11 when they updated it in 2021. It was not covered on health plans until March of
12 this year. So that's I think something where I don't know if we have that ability
13 from this Committee from an enforcement perspective but I think if you are going
14 to ask for us to do something from a measure and we are adopting a HEDIS or,
15 you know, a standardized measure, it needs, it needs to be covered so that our
16 patients can actually use that and get access to that. So I think that's something
17 that I think is very important with anything that we choose. And if that could
18 come out of this that would be very good from, as I said, the patient level. Thank
19 you.
20 MS. BROOKS: Very helpful, thank you so much, Bihu. All right,
21 Alice.
22 MEMBER CHEN: I would like to skip until, or wait until Rhonda
23 gets back because I also wanted to address the prostate cancer issue, if that's all
24 right?
25 MS. BROOKS: Okay. Dannie, you are up next.

1 MEMBER CESEÑA: Hi, Dannie Ceseña, he/they pronouns,
2 California LGBTQ Health and Human Services Network. Again, you know, thank
3 you for these focus area measures. I had some questions regarding the
4 descriptions. You know, kind of seeing how the measure has the potential, you
5 know, to obtain data, you know, regarding women, you know, with, who got
6 chlamydia screenings or breast cancer screenings or cervical cancer screenings.
7 How are you going to ensure that those who identify as trans-
8 masculine or non-binary or somewhere else on the gender spectrum who have
9 feminine reproductive organs are included in these measures? Especially since
10 27 percent of Generation Z, which is up to the age of 26 here in California,
11 identify as something other than binary woman or binary male but identify as
12 other. Which I know SOGI data in the medical field is not perfect right now and
13 really a lot of places do only ask, you know, are you male or female, and so
14 might have the other box. But, you know, I just really wanted to make sure that
15 this Committee, especially since like I said, over a quarter of California's
16 Generation Z is outside of the gender binary, that they are not left out of these
17 measures.
18 MS. BROOKS: Ignatius, do you want to say a couple words on
19 that.
20 MR. BAU: This is Ignatius Bau. So thank you, Dannie, for both the
21 comment and the data and the context. This is clearly something that California,
22 again, as a state is going to have to work through in figuring out how to continue
23 to align these evolving notions of gender outside of the binary to take into
24 account these kinds of measures that historically have been based on a binary.
25 And so again, as we begin to collect that gender data in a more

1 comprehensive way then the measure should align. I am not sure it changes the
2 measure, it changes how we collect data about individuals, and to which
3 measure the health plan, the provider, the health system is being held
4 accountable to. It shouldn't affect the selection of the measure, it definitely would
5 be an implementation challenge that is important to consider.
6 MS. BROOKS: Thank you, Ignatius. Dannie, I just wanted to see if
7 you had any follow-up comments or questions?
8 MEMBER CESEÑA: Yeah. I mean, you know, and I totally get
9 like, you know, right now, there is, you know, not a standardized way to collect
10 this data or for even medical providers or insurances to collect the data. My
11 biggest concern is that, you know, people that are marked under the woman
12 column aren't actually identifying as women, or those that just refuse to mark
13 anything at all because it does not reflect their gender identity. That will skew
14 these numbers and everything. And then this also leaves out, you know, on how
15 we can address prevention within the LGBTQ community, you know, as we work
16 on these measures, so. But thank you.
17 MS. BROOKS: Thank you, Dannie. All right, Alice, are you ready?
18 All right.
19 MEMBER CHEN: Thank you. Alice Chen, Covered California.
20 And Rhonda, I wanted to address your prostate cancer question because just to
21 acknowledge directly that it's such a huge issue for African American men and so
22 understand why that comes to the front. And wanted to share also the Covered
23 California experience, which is really trying to figure out that Venn diagram
24 overlap of kind of disparities, urgency, with the science and the kind of
25 epidemiology and prevalence.

1 And so for example in prostate cancer, this is where going back to
2 my previous comment, the science just isn't really there yet. Like the screening
3 modalities we have are not particularly sensitive or specific, right? They don't
4 catch all the prostate cancer and they have a lot of false positives and so that's
5 why the US Preventive Services Task Force gives it like a C to D rating. And I --
6 So just to say that when we looked at these we had a similar approach although
7 we did it a little backwards.
8 We really looked at both -- well, I shared before like when you look
9 at the leading causes of morbidity and mortality it is cardiovascular disease and
10 cancer. And within cancer it is lung cancer and then colorectal cancer. And you
11 can't do that much for lung cancer but colorectal cancer is absolutely preventable
12 and it has a US Preventive Services Task Force of A. So just to share with you,
13 we looked at all of these and between the ratings of A, B, C, and then the
14 prevalence, and also just making sure we had enough numbers to be able to
15 stratify by race/ethnicity, we only landed on colorectal cancer screening for this,
16 among this list, if that's helpful.
17 MS. BROOKS: Ed.
18 MEMBER JUHN: Thank you. Ed Juhn, IEHP. So I think I am
19 going to answer number two, what I think that most health plans may, you know,
20 resonate with, at least from a managed Medi-Cal plan perspective. I think the
21 key for us is choosing measure sets where the enforcement perspective is
22 something that is feasible. So from an alignment feasibility collection reporting
23 perspective, if health plans are going to be held accountable through DMHC
24 enforcement, I think the ones that align with a lot of the regulatory pieces make a
25 lot of sense. So for example, breast cancer screening and colorectal cancer

1 screening, not only from an NCQA perspective but Covered California with the
2 Quality Transformation Initiative and the work through IHA make, make sense.
3 So I think for, for me, consideration of those two measures to move to that final
4 set. Yes, for consideration, thanks.
5 MS. BROOKS: Thank you, Ed. Diana.
6 MEMBER DOUGLAS: Thank you, Diana Douglas with Health
7 Access California. I think -- so first to jump back to Dannie's comments and the
8 responses just on how to capture the full, you know, the full picture when we
9 don't have all of the SOGI data necessarily. I would just urge the Committee and
10 members here to try to look for ways at every opportunity that we can, rather
11 than just being guided by what data is available now or what data is easily
12 available, to us this process and the power that we have here with all of us
13 gathered to go through this process of determining measures to also find ways
14 to, to push and, you know, maybe go beyond what the status quo has been. I
15 know in a variety of settings a lot of us are pushing for better SOGI data but I
16 also think that here through this Committee there are opportunities to hopefully
17 be a little bit more creative than just the measures that are there that might be
18 stymied by lack of data currently.
19 And then I think moving on, I appreciate Alice's comments on
20 USPSTF ratings and some of the thinking behind those, for example, prostate
21 versus colorectal cancer screenings. I think similar to some of the comments
22 that were made, I, you know, frankly, I need more information on the disparities
23 that exist in some of these conditions that the measures would look at before I
24 can really determine, oh, I would prefer colorectal as a measure over cervical
25 cancer screening. I think there are a lot of nuances in what disparities exist,

1 disparities in diagnosis versus mortality. I know with colorectal cancer that
2 there's the increased incidence among Black Americans compared with white but
3 also exponentially increased mortality as well so that's something that would be
4 good to consider. But obviously the clinical folks here probably have a lot more
5 knowledge on that, but a lot of us may not so I think that we probably need some
6 more context on the disparities.
7 And to that point too I will just take the moment to say that it would
8 be really helpful to be able to continue to provide written comments here as well.
9 I know we have a limited amount of time and a limited amount of information that
10 can be communicated, especially when we are determining measures. I think,
11 you know, we might need time to dig into some of the disparities a little bit more
12 beyond what we are able to discuss at the meeting and beyond the information
13 provided here. Thank you.
14 MS. BROOKS: Thanks, Diana. I see Robyn.
15 MEMBER STRONG: Hi, Robyn Strong with HCAI. So I have a
16 couple comments regarding some of the disparity parts of this discussion and
17 one is on the subject of race and ethnicity. We had -- part of our discussion there
18 was something about the multiracial bucket. And I will just caution that that may
19 kind of make some of the data generic and that people may not be represented if
20 they are just, you know, one-size-fits-all check, I am multiracial.
21 So in the claim forms that I have, that I have mentioned before, the
22 claim format, there are multiple spaces for including each individual race that
23 somebody may be part of or, or can self-identify. So that gives the opportunity to
24 bring somebody in who is both Native Hawaiian and Black and be able to be
25 counted in both, both spots. And so whatever we are looking at we can identify

1 disparities that way, rather than having a generic one-size-fits all, multi. So when
2 we collect the data at that level with multiple options then we can, we can identify
3 also, that person is multiracial and that gives it a value-add. So I just wanted to
4 make that, that comment on that category.
5 In another area, as Dannie said, with the sex and SOGI because,
6 you know, there really are three different components there, that data is not
7 readily available in the claim format. And so we do have the opportunity to, you
8 know, make asks of, say, the X-12 committee that creates and makes changes to
9 that claim format and then standards can be put in place so that that data is
10 collected the same and we can align nationwide.
11 So the US, part of the Office of the National Coordinator, ONC, has
12 what is called the US CDI, so that's the United States core data for
13 interoperability. That data set that they have created has data elements for all
14 three components. And so if, if we can work with something that has been
15 established already and then get that into the claim form, or what is used for
16 interoperability for paying claims by plans, then that gets us there. I realize this is
17 much bigger than this Committee but I would really like to see alignment and
18 maybe some effort in, in getting those kinds of fields established so that we can,
19 we can collect data that, that aligns with that.
20 There also to the point of the disaggregation of data. There are
21 reference tables. In fact, I have been working with the CDC in the last couple of
22 days. There are reference tables that have hierarchical race and ethnicity
23 categories and so that's something we can leverage as well. That people can
24 report to the level of granularity that is collected. I covered a lot of territory and
25 those really weave through each one of these focus area. So I have said my

1 piece for this one and really that will, I'd like those comments to carry forward
2 with the other focus areas as well.
3 MS. BROOKS: Great, thank you, Robyn. And I have never heard
4 of X-12, it sounds super interesting. Silvia.
5 MEMBER YEE: Thank you, Silvia Yee, DREDF. This isn't a
6 question but just in reference to what Robyn said. The Office of the National
7 Coordinator has, recommendations have been made from the interoperability
8 standards work group regarding sexual orientation and gender identity as well as
9 three elements related to disability. So just wanted to elevate that. And they are
10 taking public comments until April 30 so support those recommendations.
11 My question was actually thinking a little bit about Ignatius's and
12 Andy's response to Dannie's question earlier. It does make sense this kind of
13 like separating out. The measures themselves are one thing, and how you
14 collect the information, if you can, is another. But I think there is also a
15 relationship between them. I mean, I look at this list, this list here, and thinking
16 about breast cancer screening, colorectal cancer screening, chlamydia
17 screening. I can see how people with disabilities have had, experienced
18 disparities related to all of them and many of those are documented. If you can't
19 stand for a breast cancer screening that requires you to stand you are not going
20 to get screened and so forth.
21 If I knew now that disability was going to be included in the, the
22 stratification of data, then that's one -- if I knew already at this point. I don't. And
23 because that disability data is not commonly collected now. I mean functional
24 status. Can you see? Do you see what significant difficulty? Do you have a
25 mobility disability? That kind of functional; not the diagnosis. Because I don't

1 know that that, that stratification will happen. It becomes more important to me to
2 have some kind of measure that captures some element related to people with
3 disabilities. I'm grasping at a part to take care of the whole because I don't know
4 that I will be able to get that data.
5 It relates as well to sexual orientation and gender identity. For
6 example, colorectal cancer screening may have the highest standards, but
7 everyone is supposed to get colorectal cancer screening. If you are looking at
8 breast cancer screening you are looking at gendered testing and it allows you, if
9 you are collecting that, to maybe get at some -- to maybe expose some of the
10 problems and disparities related to transgender identification, sexual orientation
11 and not having that information.
12 So it just makes me -- if I can't get the whole, the whole complete
13 picture, I am going to be grasping harder to get at these other ways of exposing
14 something. So if I am looking at this and I am thinking, well, two to three and
15 ultimately it may only be one, I am thinking of a set that will look at age,
16 chlamydia, breast cancer, and colorectal. But in the end maybe only one of them
17 will be there. And it might be colorectal because it has got the best standards,
18 the gold sort of standard. But again, it won't capture the picture of disparity
19 related to sexual orientation and gender, gender identification. So I just wanted
20 to say that I think that's the relationship and why I can't just say, Well, yeah,
21 yeah, let's decide one thing and then the other.
22 MS. BROOKS: I think you are making an important point, Silvia, in
23 that, you know, there is clear connection between the issues that you are talking
24 about. You know, we keep coming back to the charge of the Committee with
25 respect to measures but I think that, you know, it is hard to think about the

1 measures without thinking about the data sources themselves, and then also
2 stratification of the data and what's collected and so on, so really appreciate you
3 raising those points. Anna Lee.
4 MEMBER AMARNATH: Hi, Anna Lee Amarnath with Integrated
5 Health Care Association. I just want to thank your team for the hard work of
6 creating these tables because I recognize how hard it can be to decide where
7 measures should fit. And I even found myself opening multiple tables to look; I
8 was thinking a measure would be on the prevention table. Oh, no, it's on a
9 different one, okay. So I am finding the measures different places so I just
10 appreciate the work that you put into that.
11 I have a natural tendency to want to measure everything. It's just
12 my personal biases. Yet, my comments are going to potentially be to suggest
13 there is a measure here that I don't know that I would necessarily recommend or
14 I think we should talk about it. And it is more from a feasibility perspective and it
15 has to do the smoking cessation measure that is here. It is the only measure on
16 this list that is at least highlighted in green that is a survey measure. And it
17 caught my attention because I think of that as a caps measure, a consumer
18 survey measure, a patient experience measure, because it is a patient reporting
19 their experience of having smoking and smoking cessation discussed with them.
20 So again, I could have bucketed it on a different list is where I
21 started, but just recognizing there are some limitations on how surveys are done
22 and sample size that is collected, limitations in even just the languages that the
23 surveys are available in and validated in. So as we start to think about is that
24 measure, how we could use that measure not just to assess performance overall
25 but if we start to think about disparities and how could we look at that measure

1 and how does that apply from a perspective of disparities? Are we able to
2 generalize that survey measure for the types of populations we might want to
3 stratify by, may depend on how we are sampling and how are using that
4 methodology.
5 But I also recognize, I personally think it is very important to be
6 thinking about how we are addressing smoking and smoking cessation and
7 outcomes that are impacted by smoking. And I recognize that this is an area
8 where what we might want to do could be impacted by what measures are
9 available to us as well. There's limited, there's limited measures that look at
10 smoking from a more holistic approach or from claims or other data sources.
11 There's just limitations and how that's documented to be captured and data. So I
12 both, one, think it is very important to be looking at and measuring but I am
13 struggling with this particular measure as one that we should consider as one of
14 our top priorities if we do have to limit.
15 And I just don't know, I don't want to put anyone on the spot, but I
16 recognize that Covered California is using this measure and I thought maybe,
17 Alice, you could speak a little bit about your experience of choosing that measure
18 and maybe that would contradict what I am saying. So I would love to hear your
19 thoughts on that measure if you are willing.
20 MEMBER CHEN: Alice Chen, Covered California. I think I am
21 going to reinforce your point which is we have chosen this measure because
22 smoking and tobacco cessation is so critical for population health and there are a
23 lot of disparities and we have had a really hard time getting our arms around
24 complete and accurate data for all the reasons you have talked about. It is just
25 not -- we have claims data and it is just clearly incomplete. The smoking

1 prevalence is very, very low. I mean, much lower than you would anticipate.
2 And then it has been hard to match the claims data for prescriptions and non-
3 pharmacologic therapies.
4 MS. BROOKS: Thank you, Anna Lee and Alice. I would just see if
5 there are any other kind of comments in response to what was raised or
6 questions. All right, other? Lishaun.
7 MEMBER FRANCIS: Thanks, Sarah. Thanks so much for putting
8 all this together. I just wanted to reiterate everyone's comments about the
9 importance of disaggregated data and the importance of demographic data. But
10 if I am looking at the prevention measures as presented it is easy for me to notice
11 the lack of health-specific perfect measures. And specifically well health visits
12 have always been really, really important to us in the prevention world as well as
13 the oral health measures that exist in the prevention world. I just want to flag
14 those two as ones that we would like to see on some of the final lists. And
15 particularly as we think about breaking it out by race and ethnicity, because we
16 also know that well health visits, that some families are getting the well health
17 visits that they are supposed to, depending on what they look like. So would love
18 to dig more into that but that is a measure that I wanted to uplift.
19 MS. BROOKS: Thank you, Lishaun. We have taken note of that
20 and I think that's, you know, another example of -- it looks like Ignatius and Andy
21 may have a comment as well.
22 MR. BAU: So this is Ignatius. There's another example where we
23 just made the choice of where to put the measure for discussion purposes. So,
24 Lishaun, when we get to people who give birth and children you will see the well
25 child visit measures as well as some oral health/dental visit measures.

1 DR. BASKIN: This is Andy Baskin. Another thing you want to keep
2 in mind when we do get to it is that let's remember, this is not just for Medi-Cal. It
3 is commercial as well and commercial plans in terms of coverage of dental may
4 be different than Medi-Cal. And we need the measures, at least for the most part
5 we'd like these -- these measures are going to be for everybody. Just have to
6 keep that in the back of your mind as to the impact it will be because the, the
7 greater population in terms of numbers is going to be commercial members that
8 are being measured here. Not that that should stop you but I am just pointing
9 that technicality out.
10 MS. BROOKS: All right. Thank you, Ignatius and Andy. And I was
11 trying to flip ahead because I thought they were in there but I just couldn't get to
12 that slide so thank you for catching that. It looks like, Rick, you have your hand
13 up next.
14 MEMBER RIGGS: I do. Rick Riggs here. Another technical piece.
15 I don't know if the NCQA has updated their colorectal cancer screening age
16 range?
17 SPEAKER (OFF-MIC): Yes.
18 MEMBER RIGGS: They have. So this is just --
19 SPEAKER (OFF-MIC): That was in March.
20 MEMBER RIGGS: Right. So this is just not updated.
21 SPEAKER (OFF-MIC): It was just done in the middle of March.
22 MEMBER RIGGS: Perfect. I just wanted to make sure we were,
23 yeah.
24 MS. BROOKS: Other comments or questions just in this area? I
25 guess, want to bring us back to the questions on the Committee discussion list. I

1 didn't, definitely we took note of some different measures that were raised for
2 consideration. We talked about vaccinations earlier, we talked about some
3 measures that may be grouped into other focus areas that are important.
4 Wanting to kind of circle back on to the second question to see if there are
5 candidate measures. You know, if they are within this groups here are ones that
6 would be more prioritized over others by the Committee or what your thoughts
7 are with respect to that?
8 SPEAKER (OFF-MIC): (Inaudible.)
9 MS. BROOKS: Yes, just prevention specifically, yes. Thanks for
10 clarifying that. Bihu, go ahead.
11 MEMBER SANDHIR: Bihu Sandhir from Alta-Med. What I am
12 understanding is you are asking for recommendations of whether we should
13 adopt or at least move them up to the next level?
14 MS. BROOKS: Yes.
15 MEMBER SANDHIR: I would actually say all three, breast cancer
16 screening, cervical cancer screening, colorectal cancer screening. They all have
17 high impact, they are fairly standard. They are very standard. We have a lot of
18 data on that. And they actually do cover a lot of the disparities that we have and
19 which we need to address, I think, in there. But I would actually recommend all
20 three.
21 MS. BROOKS: Thank you, Bihu. Comments in response to that
22 just from Committee Members for right now? Bill, did you have -- others?
23 I guess looking at the other measures that are listed here,
24 chlamydia screening is one that I haven't heard come up necessarily. Is that one
25 that anyone feels strongly about here maintaining on the list? It is obviously

1 important and has disparities but just wanted to kind of see what people's
2 thoughts are on that measure. Silvia.
3 MEMBER YEE: I was just, I just don't know. When is cervical
4 cancer screening recommended, at what ages? Twenty-one on? Yes, I just
5 thinking, I just wanted to make sure there were measures here that younger
6 people also --
7 DR. BASKIN: Just to help out. When you do look at the workbook
8 it does have a short description and if there are age limits they are always in
9 there. So just for notice for anybody that needs to know. You certainly can ask
10 as well, by the way, don't get me wrong, but it does provide them. Because
11 some of these measures obviously have older age groups, some have,
12 obviously, children-related and some are across multiple ages.
13 MS. BROOKS: Thank you, Andy. All right, Diana, I saw you put
14 your hand up.
15 MEMBER DOUGLAS: Yes. I think just on the topic of age, too. I
16 think just keeping in mind DMHC plans are likely for folks that are 65 and
17 younger. So I know for some of these screening measures I am seeing that go
18 up to 74 or 75. Then there's potentially, you know, about half of that age group
19 that it would apply to are likely or potentially not on DMHC plans and would be on
20 Medicare. So I think that's something else to keep in mind. And also again if we
21 can put a finer point on where the disparities lie within a younger versus older
22 age group that could be helpful in determining how useful they would be as well.
23 MS. BROOKS: Thank you. What I am hearing from the group is
24 maybe to include breast cancer, colorectal screening and -- I wrote down breast
25 cancer twice, sorry. Cervical cancer screening. Are there -- Anna Lee, I know

1 you made some comments, but are there other measures that are listed here or
2 any others that we have not talked about that we feel like need to be prioritized or
3 put onto the initial list of measures that will be considered as a whole kind of later
4 on? Anna Lee is raising her hand.
5 MEMBER AMARNATH: Anna Lee Amarnath, Integrated
6 Healthcare Association. So now I am going to do the opposite which is tell you,
7 you know, things I couldn't find on any of the other lists that I was like, oh, this is
8 an opportunity. I am just going to say adult immunization. I noticed a lot of the
9 ones I thought were missing at first I found when I went to the child workbook
10 and I was like, okay, there's the wellness visits and there's different things,
11 immunizations there.
12 But just I think there's a real opportunity. And I saw prenatal
13 immunizations also in one of the other workbooks, immunizations and flu shots.
14 And as we are thinking, I mean, COVID and things like -- I think there is an
15 opportunity to look at using this as an opportunity to look at measuring adult
16 immunizations. Which I also have to acknowledge from a feasibility perspective
17 we don't do as great a job as providers utilizing registries, etcetera, to collect that
18 data. But I think there's a real gap that we could be potentially utilizing this as a
19 forum to begin to address.
20 MS. BROOKS: Thoughts about adult immunizations, adding that to
21 the list? I see Alice's hand is up.
22 MEMBER CHEN: Alice Chen, Covered California. I would really
23 second the consideration of adult vaccinations, in particular thinking about the
24 COVID-19 vaccine.
25 MS. BROOKS: Thank you, Alice.

1 MEMBER CHEN: Actually, sorry. I had the other thought which is,
2 I struggle a little bit about using these measures as a way to -- or I am ambivalent
3 about like surfacing the needed changes in terms of like how long it will take. But
4 I totally get the fact that like cervical cancer could really surface, you know, SOGI
5 data needs, for example. This would serve, potentially accelerate kind of data
6 exchange between public health and health care in a way that could be very
7 beneficial. But again, I hesitate a little bit because I am not sure if that's the
8 primary goal of the measure set.
9 MEMBER RIGGS: So I'm sorry, I am not sure I followed the train
10 there. Was the adult -- recommending adult vaccination consideration of COVID
11 vaccination?
12 So I guess my only point, our only reflection on that is that our
13 definitions of what's up to date vaccination for COVID-19 have been challenging
14 with regard to boosted, non-boosted, fourth booster, immuno-compromised. I
15 mean, so. And I don't know where we are going to -- if this is a five year
16 measure I don't know where that takes us with regard to that piece and I don't
17 know that -- the science has been rapidly evolving, as we have seen with
18 COVID-19. So that's the only comment I would make. I think it is a hard, it is
19 difficult to know where, in the crystal ball where we will be in five months with that
20 particular. And sorry, this is Rick Riggs again.
21 MS. BROOKS: Thank you. Go ahead, Alice.
22 MEMBER CHEN: Alice Chen, Covered California. I think your
23 point is really well taken and I wonder for many of these whether we want to point
24 the measure specification either to NCQA or to CDC or whatever the, or US
25 Preventive Services Task Force, so that we have some flexibility in terms of

1 changing guidelines.

2 MS. BROOKS: Okay, maybe just real quickly, because then --

3 DR. BASKIN: Yes, it's Andy Baskin. The changing guidelines. In

4 general these measures are updated to the changing guidelines as they occur,

5 NCQA does it within, within the next cycle year every -- even the -- even the

6 measures that go to endorsement have -- there's a process when the guidelines

7 have changed. I mean, we'd have to talk about how to do that practically with

8 DMHC but I would think that they would want to use the measure that is updated

9 at the time it is updated for the next year. They usually, I know NCQA measures

10 how much difference it would have made to use the old version versus the new

11 version in terms of, you know, ranking health plans or stuff like that but that's,

12 that's generally. There's very few measures that the updated measures would

13 change the ranking of the health plan so everybody would rather use the most

14 updated version. It does happen and it is irregular, it is irregular activity.

15 MS. BROOKS: Kiran.

16 MEMBER SAVAGE-SANGWAN: Kiran Savage, CPEHN. Just a

17 question for clarification on the vaccines. Is there one measure that captures

18 sort of adults up to date on all the recommended vaccines or is it all -- because I

19 saw like the flu one on there so is it all different measures?

20 MS. BROOKS: People are shaking their heads.

21 MEMBER AMARNATH: I haven't seen a good combo adult

22 measure. Flu comes to mind as one that's a good standard to kind of look at,

23 recognizing the COVID changes and what's recommended is probably going to

24 keep happening.

25 MS. BROOKS: Ed.

1 MEMBER JUHN: Hi, Ed from IEHP. I think Anna and Alice bring
2 up a really important point. I think from a health plan feasibility perspective it will
3 be important to kind of balance that right tension on how we get the information
4 in a timely and impactful manner so that we can intervene in a meaningful way to
5 the members that we serve. For us in general when you think about
6 immunizations, for example flu, sometimes they may receive the flu at their local
7 Walgreens or CVS and so they indeed have it so how do we capture that
8 information?
9 I think that also goes to the earlier comment I believe Alice made
10 regarding the scope. You know, are we going to start enforcing, you know,
11 opportunities for data sharing or data exchange so that we are able to address
12 these important issues? And I think, you know, as long as we keep that in mind
13 in the discussion I think that would be really beneficial.
14 MS. BROOKS: Palav, I see you have your hand up.
15 MEMBER BABARIA: just wanted to flag there is a new HEDIS
16 measure that is a combo adult immunization measure that I can drop the link in
17 the chat but it includes Tdap, influenza, pneumococcal.
18 MS. BROOKS: Palav, we will get that from you so we can email
19 that out to everybody.
20 MEMBER BABARIA: Yes, sounds great. And I will flag just to
21 follow-up on previous comments, there is -- it is one of the EU reported measures
22 and so you have to get leverage, electronic health record and other forms of
23 capture it is not just an administrative measure. So I think another thing for this
24 group to consider and weigh is do we want to push into this space of measures
25 that are more robust but do require data exchange capabilities?

1 MS. BROOKS: All right. Other comments in the room or on the
2 phone?
3 We will go to public comment then. Any hands up, Shaini? Go
4 ahead, caller. That's it. I think you are still on mute; if you want to come off
5 mute. Okay, Beth, it sounds like we are just having some difficulty getting you off
6 mute. If you want to try and just unmute we will wait just a second, not a second
7 but a little bit, a minute here just to see if you can get off mute because we
8 certainly want to hear from you. Maybe while you are trying to go, get off of mute
9 we will just check in the room. Is there any public comment? All right.
10 REV.SHORTY: His favorite word is bundling. Maybe we could
11 bundle the tasks here into one group; it would be a great idea. You know. One
12 of my, my daughter's mother is stage four with colorectal cancer right now so, I
13 mean. I asked her. Her thing was, even though she knows she is dying she just
14 wished it would have been caught ahead of time. So I think bundling all of that
15 together would be helpful to women and men in the state of California.
16 MS. BROOKS: Thank you for your comment. It looks like Beth,
17 you are still muted. We will. It looks like there is another caller that has a
18 comment. Can you open their line?
19 MS. TARRELL: Hello, can you hear me?
20 MS. BROOKS: Yes, we can hear you. Go ahead, Kristen.
21 MS. TARRELL: Yes. My name is Kristen Tarrell. I am a registered
22 nurse for Western Health Advantage; it is a small regional health plan in the
23 Sacramento area.
24 Because AB 133 is requiring all commercial plans to have NCQA
25 health plan accreditation by January 2026 and Covered California and the

1 Medicaid line of business in California is requiring the health equity accreditation,
2 I would like to see that a good portion of these measures use HEDIS measures.
3 Because not only is NCQA requiring a lot of these measures to be stratified by
4 race and ethnicity in the future, not just the five that are doing this year, but they
5 are all very robust and it would be easy to compare.
6 Another thing I would like to say is that we, we will be -- NCQA is
7 going to be stratifying. Not stratifying. Requiring the health plans that are
8 accredited through the Health Equity Accreditation to collect SOGI data. And I
9 know from my conversations with other health plans around the state this is a
10 very difficult data collection. One, because it is very sensitive; two, because it is
11 really becoming more on the forefront of everybody's thoughts. And too because
12 it is -- another reason is it is not collected in the EDI enrollment files so it can't be
13 collected at enrollment like race, ethnicity and languages so it makes it very
14 difficult to collect and report on.
15 MS. BROOKS: All right. Definitely understand your perspective
16 and appreciate your comment. And I think just to make a comment to -- I see,
17 Lishaun, you have your hand up, we will come back to you. Just to make a
18 comment to folks in the room, we want to take public comment before we kind of
19 make any final, have any final conversation in each section just to make sure that
20 we have the opportunity to hear from the public with respect to the discussion
21 that we are having. Lishaun, I see you have your hand up. You are on mute.
22 Just checking, Lishaun, just to see if you are there? Maybe not at this moment.
23 All right.
24 So kind of just summarizing and circling back to what I have heard
25 from you and from the Committee Members today. I heard with respect to

1 prevention specifically, in the focus area, I have heard, you know, a
2 recommendation to include breast cancer, colorectal screening and cervical
3 cancer screening. And then vaccinations of some sort, potentially looking at
4 either this new measure that Palav mentioned or a flu shot measure, potentially.
5 And so we will go back and do a little bit of research on that just to see what
6 might make sense and bring it back to you all for discussion. Am I missing
7 anything? Did I leave anything off of my summary that I just made? I just want
8 to open that up? Okay. Doreena raised her hand. Okay, I am sorry, Doreena,
9 go ahead.
10 MEMBER WONG: Yes, just -- Doreena Wong, ARI. Just a
11 question for clarification. So this is just a recommendation to move forward
12 initially; because I heard requests for more information, although I am not sure
13 exactly what more information we need. So right now generally those four were,
14 are being considered and we will come back to that at the end when we look at
15 all of the different measures?
16 MS. BROOKS: So for each of the different focus areas we will
17 identify any, we will identify the measures that may be associated with that focus
18 area and then there will be a group that we will then look at together and filter
19 down from there, if that makes sense. We won't be coming back to the full list of
20 measures but I do want to say that, you know, at any point in time if someone
21 wants to bring something or raise a measure that they feel is important that it is
22 important that you do so. Did that answer your question?
23 MEMBER WONG: Yes, Doreena, Doreena Wong again. I just
24 need clarification. So if we -- because if we end up, let's say, four measures from
25 seven different areas, there's like 28. At some point I guess we might have to

1 narrow it down and then at that point then we might come back to talk about
2 these, right?
3 MS. BROOKS: Yes.
4 MEMBER WONG: Okay. Thank you.
5 MS. BROOKS: Thank you for helping clarify that. And Bihu, it
6 looks like your hand is up.
7 MEMBER SANDHIR: Bihu Sandhir, AltaMed. I just think, actually
8 to Doreena's point, we are short-listing the measures now but I do feel it would
9 be helpful before we make final recommendations to see a little more data about
10 these measures. Some other data points like the impact, you know, we area
11 almost ready to discuss some of that. I think the disparity data at least at a high
12 level would be helpful because as we make final recommendations I think it may
13 guide us in how we choose the last set of measures.
14 MS. WATANABE: Can I just -- I want to make sure we are being
15 responsive to these requests given our quick time frame here. So I think what I
16 heard is outcome disparity measures. Do you want it specifically for the three to
17 four measures we talked about today?
18 MEMBER SANDHIR: Yes. Yes.
19 MS. WATANABE: Because I am worried --
20 MEMBER SANDHIR: Only those.
21 MS. WATANABE: -- to do the deep dive on all of these.
22 MEMBER SANDHIR: No, no, not all of them.
23 MS. WATANABE: Okay.
24 MEMBER SANDHIR: We have already short-listed them but what
25 we want is -- because we are going to be short-listing more and more.

1 MS. BROOKS: Yes, right.
2 MEMBER SANDHIR: To actually make a determination eventually
3 for your final recommendations I think that data, those data points will help us
4 drive further. Because I think some transparency will help there and take off
5 some, some of these. You know, the confusion that we have a little bit of like
6 what is the impact? I think that will be helpful to us.
7 MS. WATANABE: Okay.
8 MEMBER SANDHIR: Only the ones we choose, not all of them.
9 MS. WATANABE: And I will just say -- I mean, I heard CHIS, I
10 heard Office of Minority Health. I will just reiterate, we accept written comments
11 so from both the public and from our Committee. If there's other sources we
12 should consider please send those to us in advance. And again, we will take
13 comments anytime. We ask for you to submit them to us within a week after the
14 meeting because we start immediately planning for our next meeting and come
15 June we have two meetings so it is like, you know, instant planning, so. But
16 again, if there's other data sources you think we should look at please let us
17 know.
18 MEMBER SANDHIR: Thank you.
19 MS. BROOKS: Thank you, Mary. And Bihu, I think that was a
20 helpful clarification. Ignatius, did you have
21 a comment?
22 MR. BAU: And this is Ignatius. And, Bihu, that is also where the
23 benchmarking data will come in. So that again, we may all have an intuition that
24 California is not doing as well and when we actually look at where that
25 performance is that may also take that one off the list or we may all be surprised,

1 oh, California is doing horribly on this and we will prioritize it as we move forward.
2 MEMBER SANDHIR: No, I think that's a great point, I think that's
3 what we really need, look at all of it.
4 MS. BROOKS: All right, perfect. No more hands raised at this
5 time, so.
6 Okay, we have about 30 minutes left. We are going to keep
7 pushing through to finish not to finish, I am sorry. To start going through the next
8 section, just recognizing that we have a lot to get through for this Committee.
9 And appreciate you all sticking in here with us and recognize that we are having
10 a pretty detailed technical conversation, which is using our -- we are using our
11 brains.
12 So I am going to turn it over to -- we are going to move to slide 52
13 and we are going to talk about chronic condition disparities now.
14 So similar to what we did with prevention it is going to be the same
15 structure, no changes or anything of that sort. I am going to turn it over to
16 Ignatius and have him talk a little bit about chronic conditions.
17 MR. BAU: So, Ignatius Bau. So again we are trying to set this
18 pattern where there are some general data about the prevalence of chronic
19 conditions that varies based on race and ethnicity.
20 And a pretty detailed chart on slide 53 that shows the different
21 rates, again, by race/ethnicity for asthma, diabetes, heart disease, and obesity.
22 And then extracting some just highlights from that data. Again, please highlight
23 other points in that data as we go along. That there's, we know, a higher rate of
24 diabetes among Black and Latinx persons in California. That also means that
25 there's higher preventable hospitalizations for complications, long-term

1 complications because of diabetes among Blacks and Latinx Californians.

2 On asthma that there's a higher prevalence rate among people who

3 identify as multiracial, American Indian, Alaska Native and Black. And for

4 children in particular and adolescents with asthma there is a higher rate of

5 emergency department visits. This could have been a utilization measure rather

6 than a chronic disease measure, we just have it here, among Black and Latinx

7 children and adolescents.

8 And so again, those are ones that we just noted. And then I will

9 turn to Andy to walk through the very long list of measures here.

10 DR. BASKIN: So hi, this is Andy Baskin. As you can see we have

11 grouped the measures here within, within chronic diseases. And chronic

12 conditions, as we heard, are essentially, for the most part in terms of

13 size/prevalence there's the big three. There's diabetes, there's blood pressure

14 and there's asthma. That's not to say there aren't other chronic conditions out

15 there but these overshadow the others in terms of just volumes of people.

16 And while we didn't actually have any disparities to add on blood

17 pressure I think it is pretty, I don't have any specific data but I think it is pretty well

18 known that high blood pressure, certainly in the African American population, is a

19 larger, a bigger problem in terms of prevalence and a more difficult problem in

20 terms of treating it. Not just in treating it when you are actually taking

21 medications but then the disparities in getting treatment. So I think we could

22 safely say there will be disparities there while other data could be found that it

23 certainly exists.

24 So in doing this you can see that there's actually two slides worth of

25 diabetes measures. So it turns out to be a considerable number; it looks like

1 nine of them here. Let's talk about those first. I think --

2 MS. BROOKS: You are on slide 56, Andy?

3 DR. BASKIN: I am on slide 55 and 56.

4 MS. BROOKS: All right.

5 DR. BASKIN: Fifty-five is diabetes as well as 56 is diabetes.

6 MS. BROOKS: Perfect.

7 DR. BASKIN: So it is a lot of measures and it would be really,

8 really helpful for us to hone down. I mean, I think everybody would agree we are

9 not going to have nine diabetes measures. I think it is likely we will have at least

10 one. I don't want to, you know, speak for the Committee but it is such a huge

11 problem that it seems, it seems likely that will happen. So it would be nice if part

12 of your thinking could be, if you think diabetes should survive as a measure, or

13 measures, measure or measures, in your comments it would be helpful to us to

14 help us narrow it down to which you think may be the most important ones.

15 I will say, just like in your thinking one of the things like there's, for

16 instance, on slide 55 there's two by diabetes, Hemoglobin A1c control.

17 Hemoglobin A1c, for those of you who aren't clinicians, is just a measure of your

18 control of your sugar over a period of time, it is a very popular measure. But

19 there's two of them and one is less than eight, which means you have good

20 control, and the next one says poor control, which actually is greater than nine,

21 which is poor control. You wouldn't want to pick both of those, I mean, so that's

22 the kind of thing I would ask you to go through. You may want none of them but

23 you would only want one of those two, it doesn't make any sense to have them

24 both. So I will stop there and invite your comment.

25 MS. BROOKS: Who wants to go first? Questions or comments,

1 especially in response to Andy's kind of comment about the fact that there are
2 multiple diabetes measures. Are there ones that folks think would be, should be
3 prioritized over others? Are there other measures that you think that should be
4 included on this list? Welcome your thoughts. And it looks like Bihu has her
5 hand up.
6 MEMBER SANDHIR: Bihu Sandhir from AltaMed. Again, I really
7 appreciate how you, you know, put this before us and have done all the
8 homework behind it. And I do feel that diabetes is a very important chronic
9 disease that I do think it needs to be included, that's at least that's the control.
10 Either one of them would work, in my opinion, it doesn't matter.
11 But the question I have here is do you feel like we could maybe do
12 some sub-measures here which would be the other measures for diabetes? It
13 would be like a domain for chronic diseases. Would that be too complicated?
14 This is a thought process because these are all part of diabetes care and they do
15 really all impact diabetes care. So having maybe a diabetes control measure
16 and then having other smaller measures, the other measures that are here.
17 Picking a few that we are already actually, you know, measuring, but it does
18 contribute to diabetes care. So that's a thought.
19 DR. BASKIN: It's Andy Baskin. I just think we would count them as
20 two or three or four measures, I
21 mean.
22 MEMBER SANDHIR: It would put --
23 DR. BASKIN: But certainly that could be a recommendation.
24 MEMBER SANDHIR: That would be my recommendation.
25 MS. BROOKS: Thank you, Bihu. Rick.

1 MEMBER RIGGS: This is Rick Riggs. So I had a question about
2 the actual I'll say number figures, the lab report figures that the health plan may
3 receive. I know that we are seeing the claims data for testing but would they
4 receive the actual result? Is that something that is currently captured now? So
5 they get codes that get dropped based on the range when it is -- so it is claims-
6 based, even though we are -- so it is a type of coding piece not related to a
7 charge? Right, okay. Yeah, that answers my question.
8 MS. BROOKS: Okay, got it. Thank you, Rick. All right.
9 MS. WATANABE: Maybe could you just maybe repeat the answer
10 for the people on the phone because there was a lot of head nodding and maybe
11 it wasn't captured. Thank you.
12 MEMBER SANDHIR: The question is how does the health plan
13 know what is the range for the, for the measure, for your Hemoglobin A1c test.
14 And the way it is set up is because codes drop based on the range and these are
15 not based on -- they are not billing codes really but we call them CPT II codes
16 and that's how our system is set up so that we -- a lot of it goes from the lab,
17 where we let the health plan know exactly what range the code is in or which is
18 the control rate. So that's how we capture our data.
19 MS. BROOKS: Thanks, that's helpful. All right. Diana, it looks like
20 your hand is up.
21 MEMBER DOUGLAS: Hi, Diana Douglas with Health Access. I
22 think in general I would lean towards use of the clinical outcome measurements
23 such as the A1c levels as opposed to several I see that are whether medications
24 were dispensed. I don't know whether the measures looking at medications
25 being dispensed all necessarily include adherence or, you know, to what extent

1 captures to what extent the patient is able to adhere.

2 I see in one of the asthma measures it mentions adherence and

3 then maybe the second statin therapy, but I would just want to make sure that we

4 are maybe relying a little bit more heavily on outcomes and less on anything that

5 measures medication without also looking at adherence.

6 DR. BASKIN: I can clarify if that's helpful?

7 MS. BROOKS: Please.

8 DR. BASKIN: On that point I can clarify. It's Andy Baskin. So in

9 the statin use measures it doesn't specifically measure adherence because we

10 don't actually ask if someone took the medication. It is whether you filled the

11 medication and that is the proxy for adherence. That's as good as you can get

12 with administrative data without actually calling someone on the phone and

13 asking them, did you swallow the pill. So that's, that's how that one works. The

14 other medication measures for asthma is also whether you filled prescriptions.

15 And it counts -- it gives, it gives certain numbers of days for how many

16 prescriptions and that's how they measure it.

17 MEMBER DOUGLAS: And I guess -- sorry, Diana, again. I think

18 and part of my reasoning too is I wonder if there are disparities in adherence

19 where maybe people equally, are equally likely to pick up their medication but not

20 across different categories is likely to take it. So I think we would want, I would

21 want to know more about that.

22 MS. BROOKS: Thank you, Diana. Yes, thank you, Diana. Alice.

23 MEMBER CHEN: Alice Chen, Covered California. Primarily want

24 to echo Diana. One, I think diabetes absolutely needs to be in here. Two, would

25 say we need an outcome measure. And I think NCQA is actually bundling

1 greater than nine and less than eight. But if we had to choose one my opinion
2 would be that we should choose greater than nine because you can definitely do
3 something as a health care provider and health care system to get someone less
4 than nine. Getting less than eight, you know, may involve food deserts and
5 exercise and other things like that. But I do think NCQA is looking at both.
6 And then lastly, to Diana's point, I would advocate for staying away
7 from medication fill. Partly because health plans both for very positive proactive
8 reasons but also for check the box reasons oftentimes will do auto-fills of
9 patients. I mean, I have had patients come in with bottles and bottles of
10 medications that got sent to their house that they actually weren't taking so I don't
11 know that that's a great measure.
12 MS. BROOKS: Thank you, Alice. Rhonda.
13 MEMBER SMITH: Hi, Rhonda Smith, California Black Health
14 Network. I am just curious about any thinking around -- and sorry to go back to
15 prevention but we know that there's a high prevalence amongst African
16 Americans and Latinx populations and there are a lot of folks walking around that
17 are pre-diabetic and probably totally unaware. If there needs to be something
18 addressed in the prevention area for screening for pre-diabetes. I don't know
19 how that works in the medical field, I am not a doctor, but just know that, you
20 know, especially Type 2 is something that's preventable. So if we see a big
21 prevalence and also we know there's complications that ensue from that. Is that
22 something to consider too under prevention?
23 MS. BROOKS: Is there a pre-diabetes measure? I just want to -- I
24 am just not aware, sorry.
25 DR. BASKIN: Yeah, it's Andy Baskin. I am not aware that there is

1 a formal measure or at least one that is widely used in terms of screening for
2 diabetes. There certainly are recommendations. The recommendations may not
3 be so consistent across all the recommended, all the entities that recommend
4 and there may not be a measure out there. It would be an interesting measure to
5 have and we will go back and look to see if we have missed a measure, such a
6 measure. It is not commonly used in programs but it does make a lot of sense.
7 MEMBER SMITH: I don't know if family history plays a role in that,
8 family health history when it comes to diabetes. If that is also -- sorry, can you
9 guys hear me?
10 DR. BASKIN: -- clinicians here that can answer. I mean, certainly
11 family history is a risk factor for diabetes. Whether it is part of any particular
12 measure that is out there today is the problem. There really aren't any measures
13 that I am aware of.
14 MEMBER SANDHIR: May I respond to that, as well? So Bihu
15 Sandhir from AltaMed. There is guidance on pre-diabetes, for screening for
16 diabetes, but it does sometimes change every year as the American Diabetes
17 Association guidelines come out so I think that's where the challenge is itself.
18 And I think it will restrict because it does take family history into account as one
19 of the risk factors. It is not that every patient has to be screened. So I think we
20 will actually most likely exclude a large population of patients. And if we want to
21 have the biggest impact I think choosing one of the more outcome measures for
22 diabetes would have more of an impact, really in the end for what we are trying to
23 do over here. But as I said, I don't think there is a HEDIS measure that I am
24 aware of either for a standardized measure yet. I am sure we are going to get
25 there at some point because it is becoming more and more prevalent, you are

1 completely right, but I just don't think it is there yet.

2 MS. BROOKS: Thanks. Great questions, thank you. All right,

3 Doreena.

4 MEMBER WONG: Doreena Wong, ARI. So I just had a kind of a

5 comment about just one of the statistics around the chronic conditions and

6 disparities. Because I notice that at least it is broken down, but the Asian

7 category, I guess, the Native Hawaiian/Pacific Islanders are included in there.

8 And you know, I know, Ignatius, that there are certain populations, let's say

9 Pacific Islanders have a very high, you know, diabetes conditions. And so this is

10 like an example of like what do we do with that, right. Because I understand that

11 their numbers may be small, especially, you know, but they are higher in other,

12 some areas where we can get to that.

13 And if we want to look at outcomes and we want to look at reducing

14 disparities it would be good to try to figure out a way to try to see that, to see the

15 progress that is made in all the different populations that are disproportionately

16 impacted by these conditions. And so I guess, I am not sure I would like to. So

17 definitely it would be good to include a diabetes in one of the measures. But then

18 when it comes to how to show a goal or an outcome then I guess we would have

19 to try to figure that out again. So I just wanted just to point that out. Thank you.

20 MS. BROOKS: Thank you, Doreena.

21 MR. BAU: So this is Ignatius Bau. So this one, if you do land on

22 the, either the less than eight are over nine, those are going to be the measures

23 that the National Committee for Quality Assurance is requiring stratification by

24 race and ethnicity, including separating out Native Hawaiians and Pacific

25 Islanders from Asians, because that's the Office of Management and Budget

1 categories. So starting this measurement year, we are going to, again, as others
2 have noted, it will probably take another two years for us to get national
3 benchmark data but we will presumably because everybody who is using that
4 HEDIS measure will be reporting. We will for the first time actually have
5 sufficient numbers to create that benchmark specifically for smaller populations
6 like Native Hawaiians and Pacific Islanders. And then the question for DMHC will
7 be, how do we use that benchmark as it evolves over time for California?
8 MS. BROOKS: Kiran.
9 MEMBER SAVAGE-SANGWAN: Kiran Savage, CPEHN. I agree
10 with where the diabetes conversation is going. I would also suggest that we
11 consider the controlling high blood pressure measure because of the impact.
12 And then I have a question around the diabetes screening for
13 people with schizophrenia or bipolar disorder who are using antipsychotic
14 medications. I think it is important that we consider something that is around
15 physical health care for people with serious mental illness because we know
16 that's a place where we can make a pretty big difference. We know that is
17 something that doesn't happen well enough today. But I think my question is one
18 to Alice's earlier point whether, whether that kind of measure captures enough
19 people that we can, we can do a lot with it. And two, if there's other measures in
20 other categories outside of chronic conditions that you have, whether it is in the
21 mental health or whether it is in the care coordination.
22 MS. BROOKS: I think you asked a lot of great questions there. I
23 am not an expert on the measures specifically so I don't know, Andy, if you can
24 speak to that piece of it?
25 DR. BASKIN: I don't want to get too far ahead of ourselves but

1 when we do get into the mental health measures they generally, they generally
2 coalesce around depression because it is the most common mental health
3 condition and it is the one for which measures are most amenable for creating
4 measures, to be honest with you. So there won't be much else in the mental
5 health realm that is specific for physical health.
6 This is a very unusual measure in that it is a very small sub-
7 population for which there's a higher prevalence of diabetes and it is related
8 somewhat to the medications as well, as it turns out. It is used in a few of the
9 programs, or at least a program, although it is not widely used for the reason you
10 mentioned, that is such a small population. But it is, it is a unique measure in the
11 sense that it is a mental health issue as well as a physical manifestations issue,
12 as you noted. You just have to decide whether in the bigger scheme of the
13 measure set we are going to come up with, eventually we will have to decide
14 whether that one will go forward or not.
15 MS. BROOKS: All right, thank you, Andy.
16 All right. So we are going to go to public comment. We will come
17 back. Don't take your hands down, we will come back. If we don't get to you we
18 will take the order of your hands so that we can start with you at the next
19 meeting. But just wanted to see, Shaini, if there are any hands raised from the
20 public comment side?
21 Okay, so we will come back to you guys. Oh, yes, I'm sorry. Any
22 public comment in the room?
23 Thank you so much.
24 Ed, did you have a comment?
25 MEMBER JUHN: Ed from IEHP. I agree with the comments that

1 were made regarding leaning towards outcome measures. I think that's going to
2 be important for all the measures that we consider. Mainly because for Medi-Cal
3 managed care plans the pharmacy benefit has been carved out. So the state is
4 actually taking control of the pharmacy, I guess benefits, so just something to
5 consider. I recognize that this also is inclusive of all Californians and commercial
6 plans but specifically for the pharmacy benefit because it is carved out something
7 to consider as we go through all the measures.
8 MS. BROOKS: Thank you, Ed. Silvia.
9 MEMBER YEE: This is Silvia with DREDF. Poor Doreena is
10 having to squire the microphone back and forth. So these are primarily people
11 who have been diagnosed with diabetes and whether they are getting the care
12 they should be getting. So Type 1, Type 2, it doesn't, whatever type, right?
13 I guess I was looking at these and thinking about the kind of
14 disparity that can occur when getting the care or getting the attention of a
15 provider or plan depends upon being believed as a patient. And I was thinking --
16 so that's when -- that's when I think of the diabetes screening for people with
17 schizophrenia or bipolar disorders. I mean, they are talking about symptoms
18 when they are talking about how they are feeling.
19 There are hard numbers as well, of course, for getting the eye
20 exam or attention for nephropathy. Like I think some of these are a little bit
21 different. And I could be wrong because obviously I am not a clinician. If it
22 wasn't obvious I will confess that right now. But there is something to the --
23 again, I am looking at measures of potentially capturing disparities and the
24 results of disparities and I am just wondering if some of these capture or get to
25 something that the others don't when you don't, when you have like a hard

1 number.

2 You still have to get that test. Someone has to know to administer
3 it to you or to figure out that you are presenting in a way that I need to do more.
4 And I think that happens with some people and it doesn't happen with others. So
5 I am just raising that because I think that there's something to think about here,
6 especially around sort of chronic conditions. And I am not, you know, I haven't
7 figured out yet how that fits in but I just think it is, I just wanted to raise it. Thank
8 you.

9 MS. BROOKS: Go ahead, Bihu.

10 MEMBER SANDHIR: One comment just to clarify, just one thing
11 that might help here. So I do -- there is a subset of patients with bipolar disorder
12 because of the medications that you take for bipolar disorder can give you high
13 blood sugar so that's what this measure is. But if you are really concerned about,
14 I think that's part of the measure -- anti-psychotics. But the depression is actually
15 more common in patients with diabetes. So I think if we actually -- when we go
16 to the mental health measures that will actually cover all of that because it does
17 not matter what disease state you have when you talk about depression. And we
18 will be including the chronic disease part in that subset of patients as long as we
19 adopt those measures in depression. If you are talking about mental health now,
20 diabetes, I don't know if I, if I answered your question completely but if there's
21 other parts to that.

22 MEMBER YEE: I wasn't thinking only of mental health, I was
23 thinking of race/ethnicity as well, possibly sexual orientation, disability, just a way
24 a patient with certain characteristics presents and the care that they receive
25 subsequently, yeah.

1 MEMBER SANDHIR: Thank you.

2 MS. BROOKS: Thanks for jumping in there. All right, Rick. Oh, go
3 ahead, Ignatius.

4 MR. BAU: So the clinician should clarify. So trying to understand
5 your question. So a lot of these don't depend on the patient asking for these
6 things, these are standards of care. So if you are diagnosed with diabetes all
7 these things should happen. The provider's obligation to provide a standard of
8 care is to do an annual eye exam, to do the foot exam, to do the regular A1c
9 testing to make sure that it is under control. So it is not the patient saying, I have
10 foot pain, should I be checking my foot. Now obviously if it is more frequent than
11 the annual exam might show that is something that the patient interaction may
12 make a difference. So part of this is shifting the onus away from the patient to
13 the provider to follow the standard of care.

14 MEMBER CHEN: Alice Chen, Covered California. So I think I am
15 hearing two things. Like one part of it is we are looking for our keys under the
16 health care lamppost. So these measures are not addressing people who can't
17 get in to care. I mean, and this is a big issue in terms of underserved
18 populations, just not accessing care so they are, they are not actually getting
19 diagnosed with pre-diabetes or diabetes, they are not then getting the testing.
20 They are not then getting the meds. I mean, there's a whole cascade there that
21 this is not able to address. Is that one of the issues that -- I just want to make
22 sure I understood.

23 MEMBER YEE: Right. Actually I was thinking, these as
24 established measures probably wouldn't hit what I was, quite what I was thinking
25 of. I was actually thinking specifically of long-COVID. Which is not -- I mean, it is

1 recognized and yet not. And one gets care for it in part depending on whether
2 one is believed. In part. And I am thinking of that cluster of those kinds of sort of
3 conditions. Not necessarily that a doctor refuses to see you but once you get in
4 the door.
5 MEMBER CHEN: Right.
6 MEMBER YEE: So that.
7 MEMBER CHEN: Yes.
8 MEMBER YEE: That's a different. And maybe it doesn't fall in here
9 but I don't know where else it would fall.
10 MEMBER CHEN: Like the disparities in diagnosing cardiovascular
11 disease in women or long bone pain treatment for African American and Latinos.
12 Like there's, yeah, I hear what you are saying. Just one quick, just additional
13 clarification. This diabetes screening for people with schizophrenia or bipolar
14 disorder, two things. One is, it is a measure where if you are on anti-psychotic,
15 you are supposed to be screened for diabetes and hyperlipidemia. And then in
16 terms of this is an SMI measure. This is completely -- it is kind of
17 disproportionately owned by Medi-Cal because of the way our mental health
18 system is set up.
19 MS. BROOKS: I am going to go to Rick.
20 MEMBER RIGGS: I will be quick.
21 MS. BROOKS: Okay.
22 MEMBER RIGGS: This is Rick Riggs. So as the PM&R physician
23 in the room, physical medicine and rehabilitation physician in the room, I never
24 thought we would have another disease after HIV that we would have to learn
25 how to rehabilitate so we still don't have all the answers. So just to let you know,

1 it is, it is yeah, it is unbelievable that in 2020s we are still having a new disease.
2 But what I was going to point out prior to that was that, you know,
3 the one measure that is not on here that is the most prevalent, right, we don't
4 have anything really addressing obesity. And that's because our treatment of
5 obesity is changing habits, weight management, medication loss, bariatric
6 surgery, all of those different pieces, which are really hard and difficult to. As
7 Alice said, you can get somebody less than nine but it is really hard to do some
8 of these other pieces. It is not that we are not aware of it, that we need to have
9 this as a disparity focus, but I don't know that we have measures that we can
10 actually, you know, come up with. It is not for lack of trying but it is just, I just
11 want to point out that we are not ignoring the largest, you know, lines on here.
12 MS. BROOKS: Excellent point. Bihu, did you have a follow-up?
13 Go ahead.
14 MEMBER SANDHIR: I just -- we do actually have HEDIS
15 measures for obesity, which is a very good point, it is actually the largest of all of
16 this. There's one actually which we may want to consider, it is UDS measures.
17 That's what we have to -- we know where -- I was in FQHCs. We have plenty of
18 those in California. But the UDS measures, adult actually BMI counseling. So it
19 is actually not just measuring it, it is the counseling part, similar to what we have
20 in pediatrics. That is a UDS measure that we are using now when reporting for
21 obesity. Just something to think about to see if there's any value in looking at
22 that.
23 MS. BROOKS: We will definitely take that back and look into that
24 so thank you, to both of you for raising that important issue.
25 Okay, so we are almost at time. Thank you all. I know, this has

1 been a really great conversation. I know, it has been a really great conversation.
2 Just lots of good dialogue, contributions, appreciate everyone. Working with us
3 as we move into this new stage of being in-person again and welcome any
4 feedback into the process just as we do move forward.
5 With respect to public comment, public comments may be
6 submitted until 5:00 p.m. on April 27th. And the email inbox is public
7 comments@dmhc.ca.gov; it is on the slide here.
8 The May Committee will be held in-person at DMHC's downtown
9 office. So here again we may be in a different room but we will be here.
10 So just a couple of notes that I may have noted last time. That this
11 Committee, as you know, is an advisory board so Bagley-Keene will allow for
12 some Committee Members to attend remotely. The primary physical meeting
13 location must be included in the 10 day meeting notice so we will do that, we
14 have already announced that. A quorum of the advisory body members must be
15 in attendance at the primary physical meeting location. So for us to actually vote
16 we need to have an actual quorum of voting members. So we do ask that all
17 local Committee Members attend in-person and appreciate those that attended
18 in-person today.
19 The public is welcome to join us in-person for meetings moving
20 forward. We will continue to offer the public an opportunity to participate
21 remotely as well. We will include information about those options in the agenda
22 as we move forward.
23 Again, thank you, everyone, and we will adjourn the meeting now.
24 Thank you so much.
25 (The Committee meeting adjourned at 4:59 p.m.)

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CERTIFICATE OF REPORTER

I, JOHN COTA, an Electronic Reporter, do hereby certify that I am a disinterested person herein; that I recorded the foregoing California Department of Managed Health Care Health Equity and Quality Committee meeting and that it was thereafter transcribed.

I further certify that I am not of counsel or attorney for any of the parties to said Committee meeting, or in any way interested in the outcome of said matter.

1 IN WITNESS WHEREOF, I have hereunto set my hand this 1st day

2 of May, 2022.

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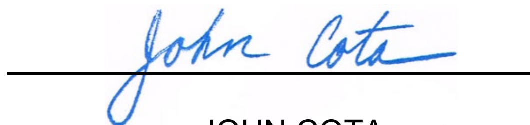
5 

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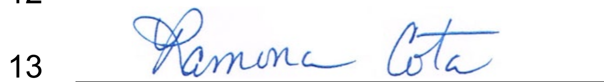
13  May 1, 2022

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