

NATIONAL QUALITY FORUM

Moderator: Elisa Munthali
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12:00 pm CT

Operator: Good day everyone and welcome to today's National Quality Forum conference. Just as a reminder today's call is being recorded.

At this time, I would like to turn the call over to your host for today, Miss Elisa Munthali; please go ahead, ma'am.

Elisa Munthali: Thank you. Hello, my name is Elisa Munthali and I'm with the National Quality Forum, the project manager for the population health project, also on the line are my colleagues Helen Burstin, Kristin Chandler and Robyn Nishimi and I'd also like to welcome and introduce one of the committee's co-chairs, Paul Jarris.

Unfortunately, the other co-chair Kurt Stange cannot be with us today. The purpose of our call today is to provide initial feedback on the first draft of the commission paper on population health.

And on the first draft of the call for population health measures which is phase 2 of the project. As you know this is the first time that NQF has embarked on an endorsement project on population health so we're very excited about the work that the committee and the commission paper authors are undertaking.

Unfortunately we don't have the slide presentation set up but I wanted to go through a little bit of background with you. One of the things I wanted to do is review the project goals and the scope and essentially through this project what we're trying to do is expand our portfolio of preventative services and broader population health measures while fostering harmonization of those measures at both the population and provide a level of analysis.

And we'd also like to put out a call for population health measures that can bring in measures that the committee can evaluate and hopefully endorse. We're conducting our work in two phases and there are two very distinct components to the initial phase.

It includes an evaluation of provider level, preventative services and immunization measures. And as you know the committee recommended 19 of those measures for endorsement and they're currently up on our website for member and public comment through February 3.

And the second component of the first phase is foundational work for a population health endorsement project.

That work includes development of an analytic framework, guidance on measure evaluation criteria and an opportunity for the steering committee to identify potential population health measures for phase 2.

As I mentioned before phase 2 is the endorsement project for population health. The paper and the commission, the paper and the environmental scan that Dawn Jacobson and Steve Teutsch developed and will present later are intended to provide additional guidance to the committee, to complement your work and the scan especially will help to identify existing population health measures but it will also help to identify measurement gaps.

These activities do not just benefit the committee but also potential developers that might want to submit to the project.

Before I hand over the presentation and the floor to Dawn and Steve I just wanted to give a bit of a background on the paper.

As you remember Dawn and Steve presented the annotated outline for the paper during our August in person meeting. And at that time Dawn was working with Steve at the Los Angeles Department of Public Health.

She has since assumed a position with the Public Health Institute but we're happy to note that she continues to collaborate with Steve.

And so Dawn and Steve I think I will - Paul before Dawn and Steve speak I don't know if you wanted to say a few words of introduction to the committee and everyone else on the line?

Paul Jarris: Yes, well, welcome back everybody, it's been a long time since we've been together and appreciate your patience. As everyone can imagine and as Elisa said this is the first time NQF has really gone into the area of population health measures.

And joining good company in this very difficult task, CMMI, centers for Medicare and Medicaid innovation is also looking at population health measures. The IRS community benefit is looking at how do we create measures and also a framework for the clinical sector and the public health sector to come together.

IOM has a committee on integrating primary care and public health so I think all these different groups are struggling with what is really a relative simple but new concept - or not a new concept

but a new practice of really defining the ways in which clinical medicine or clinical healthcare and population health and public health can start working together.

So I think we all appreciate how difficult the task is. A lot of good work has gone on as I think you'll hear when Dawn and Steve present their paper as well as when Helen presents the call for measures.

So I think we've come a long way but it really is time now to on this call for each of you to put your best thinking into these drafts to see how we can modify them and improve them.

So again thank you and unfortunately Kurt could not be here but I'll brief him later and he's been very involved to date.

Thank you.

Elisa Munthali: Thank you. Dawn and Steve?

Steve Teutsch: Good morning, for those of you on the west and afternoon for those of you in the east.

I'm Steve Teutsch and we really do appreciate the opportunity to have this discussion with you and get some feedback on the what went on over the last few months.

Elisa described to you some of the changes that we've been going through and some of the logistic issues which lead to the relatively late delivery of this to you but I do hope that you've had a chance to review it.

Because your feedback is critical to making this the best product it can be.

Paul Jarris: Can I interrupt for one second; there is some interference on the phone so if you're not speaking if you wouldn't mind muting your set that would be great.

Female: And actually that feedback is coming from Steve's line unfortunately.

Steve Teutsch: Can you hear me now, is that better?

Paul Jarris: Yes I think that's good.

Steve Teutsch: All right. But in any event the lion's share of the work has been done by Dawn so I am going to have her walk you through briefly some of the content and then look forward to all of your feedback. Dawn?

Dawn Jacobson: Thanks Steve. Hello everyone. I guess just to echo what others have said prior to our presentation this is a very exciting project. My background is both as a preventive medicine specialist and the I've been really working in public health practice for the past ten years both at the federal level where I worked on Healthy People.

And then using state and local data when I worked at LA County so I think this is a huge step forward to really rally and strategically plan and move and improve health and the conditions that allow for health in communities all across our nation.

For those of you who have seen the draft, I would like to just take a walk through the paper and orient everyone and provide a little bit of background of what went into the different sections.

If you do have the draft there on page 3 you really became centered around four aims, to really look at a variety of definitions, there's just a huge variety out there but to center really on this idea of population health rather than public health, determinants of health and then all of these efforts

both within the clinical care domain and what we call public health domain that leads to a synergistic set of health improvement activities.

And what this is right now we selected certain ways to talk about the different areas and those words are up - you know they can be changed but right now we felt that the best phrases are population health, determinants of health and health improvement activities.

Then really wanted to do a scan on what would bring domains that we could measure into existing measurement frameworks.

And that really meant that certain types of frameworks that are very good and very conceptual and different areas, were not included simply because they didn't really allow for an integrated way or consensus way to measure something.

So we really did focus on measurement frameworks. Then to use the various frameworks to provide examples of an integrated measurement framework and to help identify measures we then included as part of the scan looking at prominent national indicators sets and a representative sample of state and local planning and indicator sets to really then give examples using different frameworks that we found.

And then the final section is some of the challenges and opportunities around data availability, who's prioritizing what and how, do they use some sort of method for prioritization or not and a lot of those challenges and opportunities will be finalized after the discussion with the committee today.

Continuing to the bottom of page 3 again just for the purposes of having definitions for this report, very tricky we know, but we really wanted to be able to describe the clinical care system of really everything around what we call healthcare, medical care, treatment, diagnosis and the different

facilities that are - you know whether they're integrated or a single physician practice or a health plan would be called clinical care system.

Then government public health system is really focusing on the agencies across local, state and federal government as well as tribes and territories that really are mandated quite often to take responsibility within a geopolitical area.

And then we had a lot of good vigorous discussion about what we call all the partner organizations and right now those organizations throughout communities that are essentially to really multi-sartorial efforts to improve health we're just calling stakeholder organizations at this point.

And as we move on to the bottom of page 4, central to that is then a way that IOM has discussed these systems in the past and I won't go into the details there, if there's questions we can talk about that later.

Then page 5 lays out the three sections that I just spoke about, definitions, approaches to measurement and indicator examples and then ways that those can be prioritized and linked to that measurement framework.

And I think I'll leave it there knowing that there are more details in this section but I'm sure we'll create some very interesting discussion. Thank you.

Mike Soto: So is it open for discussion now? This Mike Soto, okay, I'll say a few words. First of all I want to thank Dawn and Steve I think you've done a terrific job of dealing with a very, very complicated and broad area and you made a tremendous improvement since that early first draft that we saw.

So I think that's really very nice. But of course I have some comments too. One thing that struck me is that you make the distinction between the healthcare sector and the government sector and then sort of treat everybody else as very much secondary stakeholders.

And I think to me you know the big point about the Figure 1.1 from the IOM report is that it really takes - that all these organizations have a key role to play.

Even though you're right, that may be the leadership with healthcare and government and public health.

But I think that it really is important to think of it as this kind of integrated system as much as possible. Can I stop there and get some...

Steve Teutsch: Mike I agree that the integrated system is very important but I can also see that given the scope of NQF and this committee and really looking at the health system broadly the two parties that are accountable would be the clinical care system and the public health system.

Most directly when you are referring to healthcare and health improvement. Having said that it can't be done without everyone around you, employers, schools, transportation, parks and recreation but they tend not to see it as their primary mission as does clinical care and public health.

So I can understand the notion that you would focus on public health and clinical care primarily and then have them reach out to the other parties.

Mike Soto: You know I think that we can have it both ways in a way and sort of get across the idea that it really takes a community, you know it takes a village kind of.

But that the measures that we've eventually developed or will be eventually developed will really primarily relate to those two. But I guess I think that we have to hold open the possibility that there are measures of accountability that relate to some others besides those first two primary ones.

Steve Teutsch: Yes I would certainly agree with that and if we look at the leading health indicators around health equity graduation rate is one of them.

So we necessarily in a committee would be looking at graduation employment, housing and things like that.

Mike Soto: Yes. Next thought I had is that the - I guess it's section two that lays out all the different models. I mean I think that you - I came away from that thinking that you guys were saying that they're all very different from one another.

And I guess I don't feel that fundamentally they are all that different. And so we've on the committee we have seen the benefit of Matt Stiefel's kind of synthesis framework, I don't know whether you guys have seen that Steve and Dawn.

Steve Teutsch: Yes we've seen it.

Mike Soto: Yes and it strikes me that I don't know whether you agree, whether you think that really does unify all these ideas.

Steve Teutsch: Yes, so Mike one of the things that we certainly wrestled with on this was those that we could tie more clearly to specific indicators or measures versus some of that were more conceptual, we found Matt's very helpful.

But more to the conceptual level of how these pieces fit together rather than being an easy framework to use for actually looking at measurement associated with them.

Paul Jarris: I think it's also a good idea whenever possible to use a national or widely disseminated model rather than making up our own if we can, we may not be able to.

But I like the idea of looking at a Healthy People or an IOM or even one of these public things like Evans and Stoddart and one of the things we might want to consider is can they be combined to say what we need to have said if none of them can stand alone.

Mike Soto: Well that was Matt tried to do in his model and I guess I thought that it did.

Matt Stiefel: Well it's Matt Stiefel, you know I think first of all I agree with the point that all of these models are a family of models attempting to describe the same very general construct of the relationship between determinants and outcomes and proven activities.

And I think that's an important point to make regardless of the model chosen. I think they are all moving that direction.

(Bobby): This is (Bobby) just to comment on the models, Steve and Dawn that were in the paper, I actually found having the different models shown together very helpful because they in seeing them they suggest to me a way in which we could improve the model that we've been trying to create.

And that is by combining the aspect - combining aspects of the Evans and Stoddart modified by Kindig model and the model that came from the IOM.

And I think that that's the case, particularly because some of the observations you make later in the paper, I think they are on - again to get at the recommendations section, particularly recommendation seven on page 29 and 30.

What the IOM model does that our current model doesn't do and the Evans and Stoddart model doesn't do and I think Evans and Stoddart may be closest in some respect to the model that we're using, gotten a draft right now, is recognize the nature of process in the production of health outcomes.

At least as hypothesized by those who have been paying attention to population health over time. It brings us back to the conversation that in order actually to have - to create healthier communities, those three segments of the system which here are characterized as clinical governmental public health and stakeholder segments actually have to be brought together.

And jointly oriented to work and that's I think - that's what I thought recommendation seven was all about and it's absent from our current - it hasn't been absent from our discussion but it's absent from our model.

So my thinking is that if our model could combine the Evans and Stoddart and IOM we are much close to both describing what we think is necessary in order to have better health outcomes.

And we would provide a much better guide to those that are suggesting the kinds of measure that would be useful in this NQF project around population health measures.

Paul Jarris: But (Bobby), this is a very helpful comment and I would agree, I think recommendation seven is brilliant and I want to use it in lots of different areas.

But what aspects in particular of the IOM model and Evans and Stoddart would you combine?

The bottom part of the IOM model is, makes it very clear what clinical contributors are and population health measures and how all these are relevant across the field in different areas.

But what aspects would you look at combining?

(Bobby): The top part of their model, the inputs to outputs portion of their model was the process portion that was - I mean it wasn't new to me but it was striking to me in the context of the conversations that we've been having.

And the bottom portion of the model is simply - it seems to me you know an example of the - of how someone might approach the domain of cardiovascular disease, domain is a bad word.

But the outcome of cardiovascular disease through the various domains that are present in our model and present in the Evans and Stoddart model to some extent.

Mike Soto: This is Mike again if I could jump in on this, I would support that I think and I think that the point that I - the version that I would bring out is the idea that we need to really distinguish between process and outcome things you know more in a more subtle and complex way in population health context than we do in the clinical context.

And so one way of thinking about it is that looking at Matt's synthesis model on the left kind of the input we're thinking about activities that we do and this is brought out in self improvement activities in that recommendation seven.

And we need to think about how they work together to contribute to the outcomes that we're concerned about. And that also brings up the idea about accountability for doing those activities which could be healthcare sector, governmental health sector and the others.

And I think there's some really good ideas about accountability in that recent IOM 2010 report that could be brought in here as well.

(Madeline): This is (Madeline), I just had a - as long as we're talking about models, I just had a question for our authors, really an impressive paper which I had a chance to look at.

But in talking about social determinants of health you don't mention the WHO, the world health organization work in that area and clearly the concept has some overlap.

But when we look at the steeple model that it might be helpful under social determinants of health to maybe replace some of our limited factors on the left with some reference to social determinants of health in the WHO work.

In addition in the population health model that Matt synthesized it's identified medical care. But we're really moving now toward a view of healthcare and the interventions from healthcare providers that really focus more on improving health outcomes.

So I was - these small changes in terminology might not seem so important but conceptually I think they might take us to a different place and maybe be more congruent with some of your recommendations.

Dawn Jacobson: Hi (Madeline), this is Dawn. Thank you for those comments. Two different - well my response to your first question, we did look at the WHO model and I actually read the whole report.

And also more on the physical environment or built environment we read through and looked at different frameworks for cumulative risk assessment, some really nice work has been coming out of the environmental health academic discipline.

And it was - you know we thought about bringing those in and I would put them in, I would delete them out and put them back in. And I think it was when I kept looking at the framework they didn't at least in my perspective walk through what Mike was saying about determinants through the processes to the outcomes.

Whereas the ones that we ended up including really hit all those elements but definitely the idea of you know bringing in something from that environmental health cumulative risk framework and social ((inaudible)) would be interesting.

You know it makes the framework bigger but quite possible.

(Madeline): Well cumulative risk is such an important factor for - and I'm not going to go there right now about sub populations and vulnerable populations so if we can have cumulative risk be an important component or be highlighted I think it would be really helpful.

Matt Stiefel: It's Matt Stiefel, one thing to add there, there are four of these models out there and if you know we can get into the dueling model discussion it's probably diminishing the (turn).

And I think you need to think about what will be most useful in providing framework and background for this call for measures and I think the most important aspect of the paper that comes out to me is that the very important distinction between - I like the categories, determinants, outcomes and improvements.

Even though there's obviously overlap between the determinants and improvement activities.

But that said I think that that framework is quite important, doesn't yet when we get into the call for measures doesn't yet jump out of that call.

But that's an extremely important topic for us to address if it's all for measures, if the call for measures of all three of those categories or just the subset of population health outcomes.

And then if so we probably need to be quite explicit about that framework and use that as the call.

Paul Jarris: So Dawn and Steve, what are you hearing?

Steve Teutsch: This is Steve so one of the things, I'm going back to the comments about the IOM model which I was deeply involved with since I was vice chair of that committee. And how that would integrate with the Kindig model, and it strikes me that what we have from the Evans Stoddart Kindig variation is something that looks at ultimate health outcomes and intermediate outcomes.

And less so about those upstream processes, capabilities and resources. I suspect that from your perspective there are things that are too far upstream in that in figure 2-2 of our report from the IOM which deals with the needs of the assessment planning priority setting resources.

Those are important but they're not necessarily what we want and so we are still primarily focusing on the right end of that process and we can clarify that.

I do think that we do have this distinction that we've got to come up with what Matt just discussed between what we perceived to be our - the original largely part of the charge which dealt mostly with the outcomes oriented measures that we're going to be striving to achieve and then integrate it back to what people are actually going to do that you can deal with more as performance measures which was a little bit beyond our original task.

But we need to signpost that, that's really what it's going to take to do things, to get - to make progress. I don't know Dawn, did you hear something else?

Dawn Jacobson: No, I mean what - I like the fact that there would be an integrated framework that might pull some of the most relevant elements into what NQF would eventually support and put out for the call.

And the one question I had and this goes back to something (Madeline) said and what I was really hoping this paper could do as well is set a way of talking about measures to prevent confusion.

So even within (Madeline)'s comment she was talking about health outcomes. I don't really know what she meant by that and I was going to ask her.

And I'm just curious if the committee has to say about whenever you're talking about these really big geographic area outcomes if we could call them total population health outcomes and everything else would be health outcomes for a particular system or organization.

Paul Jarris: I like the way you conceptualize that where there is a total population outcome which may be a geopolitical jurisdiction or more likely several geopolitical jurisdictions if you're include hospital service areas.

And the fact that you have measures for sub populations so that a given hospital or insurer sub population would be looked at in the context of the overall.

Because otherwise it's hard to understand how in a place like Seattle with a half a dozen hospitals in one area you can actually get them to relate to both Seattle King County and the State of Washington and frankly Alaska, whole (lammy) system.

So I like how you conceptualized the systems within systems and you know some of these measures, the true health outcomes, the change at a population level for example in cardiovascular mortality or infant mortality are such big and long term changes that we really do need the intermediate outcomes and we need process interventions and policies and things as surrogates for ultimate health outcomes.

Matt Stiefel: It's Matt, I would confer, three years of wrestling in the triple lane collaborative with the population health work that's probably been the greatest source of difficulty and confusion of defining what a population is.

And I like this framework a lot, the general population probably defines geopolitical and that sub population within it.

Steve Teutsch: Dawn and I wrestled with how to portray this and in some ways we discussed having something that looked more like a Venn diagram with a big circle that had the whole population and then all the small populations - sub populations within it that you could see how they overlap and interact.

But it is tricky and I don't know what speaks to all of you in terms of how one portrays this so that it's understandable to people.

Paul Jarris: Well and you said you were going to do a Venn diagram and they'd be worth taking a shot at that to see how well it works between that and the narrative, maybe the concept will come across.

(Bobby): You know this is (Bobby), I'm not sure that - well what I think is the distinction between the total population health and sub populations is a good one.

That's a very helpful one and I think that the nature of the model that we're talking about which now that I've listened to some of the other comments it's probably integrating Evans and Stoddart and the IOM as suggested earlier.

But perhaps also integrating the outer ring of the Healthy People 2020 model which gets back to (Madeline)'s observations about the importance of those.

But I'm not sure that there's anything about that combined model that is different for a sub population or a total - for a sub population health total population health in order to I think that most of us would hypothesize that regardless of whether you're talking about a sub population as it's defined in recommendation two or total population health as it's defined in recommendation one, the same kinds of - the same model construct is important.

And the same kinds of measures would be important to determine whether whatever it was being done made a difference or not.

(Madeline): I think the - I agree it's very challenging and - this is (Madeline) again and let me just explain a little bit about my particular concern with it. And that is in thinking about cumulative risk for certain vulnerable populations.

Really where the cost implications and the outcomes are really very skewed for sub populations. So it may be that the only way we can really get at that is using a sub population as a general category.

But in looking at the paper and reading the paper as a whole, I felt that we haven't given quite the weight to the importance of those sub populations that cost us so much in lives and finances.

And trying to look at as we begin to analyze this kind of keeping in mind that we may be looking at different metrics for that group and how do we consider that.

So I think that the sub population that's portrayed here are a good step towards getting at that.

But I just don't want us to lose sight of those groups.

Paul Jarris: You know there's a limitation which is somewhat artificial put on this which I think proposes a public health like cutting off our right arm. Because when we talk about healthcare disparities and culturally competence will be dealt with in a separate project, I mean how do you address population health without dealing with disparities and culture competency.

It's like an oxymoron so - but I think that the way as I understand Dawn and Steve to have used the term sub population here was not by different demographic or ethnic or racial groups or vulnerable groups but was more in terms of the sub population cared for by Hospital X or Insurer Y who is a component of the overall geopolitical population.

Is that right?

Dawn Jacobson: That is correct Paul, it's - ever since working on Healthy People I really would - well it's not demographic populations, it's more systems than populations.

Paul Jarris: I think we should be clear though...

Dawn Jacobson: Way to be tied in and it's a way Healthy People has always done it, is no matter what you're measuring you assess it by different demographic groups. And really on any level of these

measures, within a health plan, an integrated hospital system, a local health department, or total population health, you can break it down and look at ethnicity or age or gender.

Income level as long as your data set allows for it and it sort of - it should be really involved in anything you're measuring.

Paul Jarris: The Venn diagram I think will be helpful. There's also notion that I thought was provocative in the paper about super populations, you know like for example the work of the American Cancer Society which would be maybe that's the right word.

But it's you know it affects a number of geopolitical populations across the country. So I just think we need to be very explicit about defining what we mean. I like the idea of sub and maybe super.

And then in the call for measures being very requiring explicit - not the definition of the population but measure proposed.

Steve Teutsch: This is Steve, so let me see if I can capture this. So we have these sub populations that are basically ((inaudible)) areas or serves populations by some geopolitical organization that we talked about here, we diagram that like a Venn diagram.

It seems to me that what I'm hearing here is since - whether it's the clinical care system is going to bring one set of interventions to the table, other stakeholder groups are going to bring some others.

In (toto) they're going to cover everything that is in an ecologic model that will deal with the outer ring as you called it all the way to the very inner ring. But they come from different parties.

And we can indicate I think that diagrammatically that one could think of a vulnerable population and make a circle for that and begin to show how that - how all those pieces come together to focus on certain parts of the population.

Each of them bringing the parts that they are primarily responsible for. I mean I have it in my head but I think we could probably do something like that.

(Madeline): Great.

Paul Jarris: And I think Steve and Dawn also if you could take a look at these different models and see about combining them together. I have to say we spent all of us a lot of time thinking about this and what concerns me is when we go into other venues where people haven't thought a lot about it, there's often a world view issue and a lack of familiarity of what we mean by a population, what we mean by social determinants.

And so you know Matt in your diagram when you talk about the social economic factors, for those of us who live in this world we know what you mean there.

But for the vast majority of the people at least that I deal with they have no idea what that means or how it could possibly relate it to health.

And that's why I really like this IOM and to an extent the Stoddart Kindig model because it teaches as you read it, if you look at the bottom 2.1 and read that diagram you come away understanding how these different factors, education, nutrition, income actually are part of the puzzle.

Whereas if we short hand it too much and just say socioeconomic factors I think people's world view will not allow them to understand it at the level that this 2.1 explains.

(Madeline): I think that's an excellent point.

Matt Stiefel: I wonder - this is Matt if we could come back to the frame of determinants, outcomes and improvement activities and clarify if ((inaudible)) in the call for measures is in all three of those categories for - in a subset.

I think it's pretty important for the model and everything else that goes forward. Technically I suppose if you look at population health measures, your own view is that measures of population health outcome and the other thing, the determinants and the improvement activities influence population health.

But they aren't population health. So I guess I just want to put on the table that it's pretty fundamental question is in the call for measures if we're looking for measures in all three of those categories.

Helen Burstin: And this is Helen, I think that's something we very much want to discuss with you. We produced the draft that's very, very broad, and I think part of the intent here is after the discussion about the paper to return to that question.

And also to return to the question Paul raised about disparity because although much of what we would be doing in the disparities current project is completely based on clinical healthcare system measures.

I still think there's an opportunity for measurement here at the population level that might be very appropriate in this project as well.

(Bobby): Wow, that's if in fact the disparity is in cultural competency projects are focused on clinical measures then we've left the true meaningful levers in health disparities untouched.

Helen Burstin: Or they could be added to this one, it's really up for discussion. We're expecting the call from - Robin probably remembers this the call for measures closes - it just closed.

So we can check to see what we've gotten in. My understanding is there was not a lot that really went outside the clinical space which means because this project is now still has an open opportunity to change our call for measures, we could put the population disparities back in, that's all I'm saying.

(Bobby): Well could you - and I'm sorry if I missed this but could you send us their call for measures so we understand and any - if they have a document similar to this document we're looking at, anything like that so we could understand how they conceptualize?

Female: Sure, we can send that. I think we - it's the same document we used as an example earlier in our ((inaudible)) so we'll send it again.

Paul Jarris: Okay but in light of this and I think we'd all lose our public health card if we were part of a process that left out all the social determinants and factors around health equity.

Female: Will you send that information to us all?

Helen Burstin: Sure, yes, we'll send it to everybody.

(Bobby): And one of the things I think - and I think you just mentioned this Helen that it would be helpful to do is in reading the call for measures and this paper they aren't completely aligned yet.

And so one of the things that might be helpful is in addition to our group looking at it, maybe Steve and Dawn you could take a look at it.

Because I think it's going to be very important that we do ask for process interventions and policies and things like that as well as intermediate outcomes and health - and ultimate health outcomes.

So much of what will drive improvement for example in infant mortality are the processes and policies that have to be passed at both the governmental and clinical level.

And so if we don't address that, I mean it's lot like the way we looked at diabetic control when that first came out clinically, look at diabetic mortality, we actually started with do you even have an A1C?

And then it progressed to the level of A1C and the frequency and multiple measures combined together. That process is really important as we start out on this new venture.

Matt Stiefel: And it's Matt, I agree. And so my vote would be to include in the call for measures, call for measures in these three categories and be quite explicit about - in the proposal for measures which category the measure is in.

Dawn Jacobson: This is Dawn, just a brief comment on that just having worked in measurement for the early part of my career. What I would recommend is that if someone puts a request in that they would attempt to connect them.

Otherwise what might happen with that is that people will just start listing 20 activities and they won't connect it to their outcomes of interest or they'll pick a social determinant which influences 1000 indicators.

But you know if there's a way that it could kind of be specific across all three for whoever submits.

(Bobby): This is (Bobby), I like that idea a lot because I had the same fear.

Matt Stiefel: And how does that jibe with the - go ahead (Bobby).

(Bobby): No, I think and it also encourages those who are submitting measures to consider the framework that we are creating, the models that we are creating around population health in its entirety.

And to make those connections, and I think ultimately also for the purpose of data collection and research, it will allow a number of hypothesis to be tested about the population health model that's out there to confirm that in fact it's the correct one.

Or it will tell us what needs to be adjusted over time.

Paul Jarris: How does that notion Helen jibe with - I don't recall the specifics, we went through the evaluation of criteria document, how does that jibe with the NQF process?

Is that something that's applicable?

Helen Burstin: I think it's something we could definitely consider. I actually like that idea and if anything I found myself wanting to go even further and would love to if somebody puts forward a population health outcome measure, perhaps even have them identify you know what might that measure look like at the sub population health system level just so we again try to get a sense of that alignment if we all work together how can we improve that ultimate outcome?

Mike Soto: This is Mike, I was thinking about that when I was looking at the draft criteria earlier too and then you know in the clinical world we think in terms of structure process and outcomes.

But I think in the population world we need to think more carefully about how the measures relate to a bigger model of how health is generated and these frameworks help us to do that.

So rather than just saying if it's process, what's the evidence you may say how does this fit into the framework?

(Madeline): So I think that goes back to my questions about why in our model, our (sefo) model we have the little box that says only medical care?

Because a lot of what we're looking at this call and what we're speaking about with health behaviors there are a lot of other systems and providers who give non-medical care, who give healthcare and I would feel more comfortable if we addressed that broader realm rather than limiting it to medical.

Paul Jarris: Yes I would agree and I have gotten that reaction from some other folks who have seen the model in terms of the questions is well where is public health and it really comes down to the socioeconomic factor box, a little bit in health promotion.

So it's not as - I think it's not as - it's in there if you look for it but it's not as clearly laid out and it doesn't teach as well as like this IOM model does.

(Jackie): This is (Jackie), there is one other thing since we're talking about Matt's model, that idea at the top where equity is at the top, it sort of relates to the where is public health in this too because outcomes for public health are very concerned not just with equity but with affectedness and efficiency, you know because we're using public resources allegedly or ostensibly to do that.

So I think that needs to be expanded, that box there so we don't just want equitable care, we also want efficient and effective and then I was thinking maybe the way to bring the population held out was to sort of change the level of the boxes a bit so that the medical care for - moves a bit down and is not on the level of the prevention and health promotion.

So it gives you a sense that there's an overarching system that is looking out before illness occurs and then medical care comes in.

Paul Jarris: When I look at the model again it wasn't clear to me whether it was to be read horizontally or vertically or horizontally and vertically simultaneously.

Matt Stiefel: It's recursive in many aspects so I think the answer is yes, there are a lot of - there's a lot of feedback in all of these models that aren't shown. And that one of the problems in general with the models is that it doesn't show the richness of interaction that - this tends to but it's by directional arrows.

And - but that's a challenge to think about a true model where I mean well being ultimately is influential on the upstream factors. So...

Mike Soto: It's interesting because if you drew back you know go from the model and go up 100,000 feet what the model is really saying is - or whatever model we come up with is really saying is that there is a system that is - that gives us what we've got right now.

And that if we want a different set of outcomes than we have which is really ultimately what the population health model total or sub population is all about, then we have to change the inner workings of that system.

Paul Jarris: Multiple systems.

Mike Soto: Well yes, it depends how high up you go, how many of those individual subsystems you can see. But that idea that it's the collection of everything that we've got right now which is producing what the outcomes that we have.

And if we want a different set of outcomes we really need in some fashion to change the way in which the gears work. That's a concept that I think somehow needs to be embedded in our call for in our model and in our call for measures as well.

Steve Teutsch: Steve again, there's systems dynamic models that actually capture a lot of these things.

The problem is they end up looking like spaghetti diagrams too and so part of the challenge is that we're trying to convey complex concepts in a simple and understandable way which - and yet by the very nature of doing that you lose the complexity.

So there clearly isn't a perfect solution here but we do need to hit on sort of what are the target audience needs to be able to understand and begin to generate you know use them in an effective way.

(Jackie): Just to get back to that point about the paradigm, the idea that that's a very profound idea that what we're actually modeling is what exists. And it's very challenging to think of modeling what we want to have.

But that's - it's hard enough to model what we have so I think that's very profound and deserves a little thought or discussion I think.

Paul Jarris: We may be asking too much to define the perfect model. I mean it's so complex and it's hard to imagine there could possibly be a perfect model.

That's why I think looking at combining a couple of these and the more I look at this IOM Figure 2.2 and 2.1B I really like the fact that it talks about domains, measures, stakeholders, it talks about clinical and then a multi-element approach.

So you know what we need is in there somewhere and the fact that it names the stakeholders is pretty important, so that people don't look at it and say well what's this got to do with me?

Everybody's in there, meaning relevant measures can be put forth by numerous different parties around population health which is what we need, it brings the whole system together at some level.

Dawn Jacobson: Paul this is Dawn, the one thing I do not like about how that's labeled is to me the clinical approach is part of the determinate. And so I would label the green box something else.

I struggle with that on that.

Paul Jarris: Yes, on the other hand you know if we look at - and every - if we look - the clinical sector is so powerful that they've got to be name specifically otherwise they'll say what's this got to do with us, this is somebody else's thing.

And I think when we were on and I think it was actually you Matt who came through with the breakthrough on that NQF population health sub committee was the three levels, you know the clinical level, the behavioral factor level and the policy environmental level as the three components of population health.

That was important because those are each of those parties can then see who should be involved there. If we had said clinical medicine isn't part of population health that's clinical medicine, we would have gone nowhere in the national priorities partners or NQF.

Mike Soto: You know another line of thinking gets I think to the same place, this is Mike again, if you think about how these measures will be used I can imagine especially two things, one is the community health needs assessments at the new IRS requirements call for.

And the other one is the public health accreditation standards and they both you know require measures of population health outcomes and the inputs in terms of their performance improvement plans and so on.

And so it's going to be really the hospitals and the health departments who have the most direct role but the whole idea behind both of those things is to kind of think how the rest of the community can be involved as well.

Matt Stiefel: It's matt, just one - you know Paul I think you're right about it's almost impossible to have one simple enough model to describe all of the important factors.

So IOM I think does a great job at determinants and a poor job at articulating what is population health. It just says intermediate and health outcomes.

And you know there's important distinctions and I think that are an important part of the equation about where there's physiology and disease status, injuries and health functional status and well being.

And those are all different notions and that's key, I would argue an important part of what we're talking about when we're talking about population health outcomes.

Paul Jarris: Yes, there is that nasty definitional problem, isn't there. But I actually like the way it was handled in the paper where rather than coming up with one definition you're saying the definition varies by where you're looking, where you're sitting and what you're looking at.

Okay so Dawn and Steve and - what are you hearing?

Steve Teutsch: I'm hearing there's no perfect solution here.

Matt Stiefel: It's Matt can I just - one thing first, I just wanted to emphasize I think Dawn on this in the call for measures I think it's very important that a very useful one that I do think we need to clarify determinant outcome.

And - but the point she made about if you're going to propose proven activities for determinant measures if there's a requirement that you use one of these frameworks to show the causal pathway ultimately the population health outcomes.

Because I don't think it's sufficient just to be in the framework somewhere and talk about determinants or intervention.

Steve Teutsch: The good news actually our task is mostly to lay this out, your task is to figure out what the solution is. It's - because you know we'll try and do a little work on all of this but I'm not sure we'll get to a great unification of it all.

Paul Jarris: Well in the end we just have to make an arbitrary and (capriced) decision so please get us as close as you can.

Steve Teutsch: Yes, I'm hearing that we've got the right components in there and we'll try and work on that. Dawn you wanted to say something.

Dawn Jacobson: I think since the conceptual - the way the definitions were conceptualized since that is resonating with the committee what I would like to try to do is however we integrate the different existing framework, start putting total population health and really try to create ((inaudible)) a way of talking about that is common language.

And so I'd like to see that on whatever framework we pick.

Paul Jarris: Or whatever frameworks you combine.

Dawn Jacobson: Right.

Paul Jarris: Yes.

(Frank): This is (Frank) from Philadelphia. I'm - you know I'm just - I'm a pulmonologist, I work in a hospital and I struggle to actually understand a lot of this conversation but from that point of view actually I think I'm at a little bit of an advantage honestly.

Because it feels very much like the models that we're trying to build are driven by a desire to sort of accurately represent sort of how the world really works.

But it may not - that goal may not be consistent with a goal of getting good solid measures proposed and so for example what I mean by that is rather than trying so hard to accurately represent how health behaviors and education level and income and all that sort of influence access which influences outcomes, why don't we just come down from 100,000 feet, present this to the world as though they're say two or three related sister systems at work.

And then focus our complexity on the stakeholder part of it, basically talking about how non-traditional stakeholders can influence each of those subsystems in a more sort of meaningful and productive way.

Sorry if that was confusing.

Paul Jarris: No, I think you have a very good point is that within each system we think we know what we're doing. The complexity is how do we work between the systems so that when we approach an issue we have a full tool set rather than just a hammer, a nail or a screwdriver.

So for you for chronic low respiratory disease which is most of what you probably - a lot of what you spend your time on depending on what kind of pulmonologist - you know if we were to take that on between population health and clinical medicine, what would all the things we would have to do throughout the lifecycle to decrease or extinguish that as a condition in this country.

(Frank): Right, exactly. So it's helping me see how I might be more effective or how I might participate in how this sort of education and income and social support systems interact with my systems on choosing antibiotics and duration of follow up and all the rest of that stuff.

Helping me see how that works might make me more effective at actually influencing the global determinants of health, then requiring that we accurately draw a picture of those global determinants.

Mike Soto: Well there are two theories at work, one theory around the clinical system is the one that you just described which is that the practice of clinical medicine might lead to better outcomes for those who are ill or injured if in fact these other conditions were part of the differential diagnosis if you will and there pay or prescription recommended.

That's one theoretical framework and it's an important one. The second one from the public health perspective is that if one can address those upstream conditions and inequities the clinical conditions will - you know in the grand scheme will disappear and obviate the need for that clinical care in the first place.

And so what we're - I think what we're trying to tease out here is that to recognize both of those frameworks but because population health is so often absent from the discussion and the funding to be certain that the second one is emphasized while we recognize the need for the first one.

(Frank): So in one model you're describing how say for example educators or something like that might impact in the first model the traditional model you tend to focus on how educators might impact the outcomes of the medical healthcare system.

Paul Jarris: That example was asthma which last I checked was the most common ER admission for Medicaid kids.

You know it's the placement of schools in low income areas near major thoroughfares affects the asthma. The running of busses outside when kid's are dropped off affects the instance of asthma.

And you know unless we affect that, those decisions like that as well as clean indoor air laws, smoking in the home, we're not going to diminish the asthma disease.

Likewise...

(Jackie): So what you're saying right there is the other argument I made about it's not just equity that we're looking for, we are looking for efficiency and effectiveness in those things.

Because you just said you know if I could be more efficient, I could be more effective if I knew these other things, and let's not forget the goal here is that we want something that we can measure.

And I think that those three concepts, equity, efficiency and effectiveness are really going to help us along the path to actually measuring something.

I mean do you agree with that Dawn because I think measurement is kind of getting very cloudy in our discussions of this beautiful model.

Dawn Jacobson: Right and one thing I kept out of the paper just for the sake of time and space is the fact that just like there are quality improvement projects on efficiency and effectiveness within the health clinical care subsystem the public health is starting to do that.

And in LA for example we're a larger jurisdiction but we look at how many tobacco policies at the city level are being passed, and that's a performance measure for us.

And if we're doing our job effectively we're passing more - you know multi-unit housing, smoke free policies.

Paul Jarris: Right, or bus running outside schools and on and on.

Steve Teutsch: This is Steve can I ask something else about these frameworks? The one thing is that they're fairly static in a lot of ways. They don't deal with things like the lifecycle which we - someone just touched upon.

And what are the things that one does that's very far upstream? SO that you have a health literate population, so as they get asthma they can use the system efficiently.

We have sketched out and we did not include it in the paper though it's published elsewhere, schemes that look at the lifecycle at least from wellness to death and then the kind of interventions that one needs to put in place that are from the very social and environmental all the way down to the treasury care and end of life kinds of things.

So that one can show what they very much like Figure 2.1 what are all the things that you need to bear if you're actually going to be working on the problems?

And then you can apply it whether it's diabetes or asthma or injuries, you can look at all of those kinds of things with that larger lens. And it does bring in some - a little bit more of the lifecycle kind of way of thinking about it all the way from the healthy person to the person who's you know going to die of a specific condition.

I don't know if that helps your thinking or not but it's another part of the framework.

Paul Jarris: It's wonderful if you can pull it off, but you're now into a three dimensional - introduce the Z axis.

Dawn Jacobson: And I would like to draw everybody back to the final recommendation, Number 13, it's a compromise, it's always difficult but it really - we have to really focus in on a couple issues.

I mean it could be an outcome - you know final population health outcome like asthma that we just decide is going to rise to the top after people submit you know their favorite sets of measures to NQF.

But you know just doing asthma is going to lead to a lot of different things being measured or just taking tobacco use or you know if you do obesity and physical activity and nutrition that could be hundreds of measures you're looking at.

Paul Jarris: If you take a broad based population health and clinical outcome.

Dawn Jacobson: Across ((inaudible)) and looking at social determinants and built environment and with the clinical care sector is doing and what public health is trying to do more effectively and efficiently with health literacy and health education.

So that's I think the challenge of the committee in NQF is to how do we start small and really do one well and integrate it so that it doesn't alienate everybody in both systems from ever wanting to do it again.

You know and that's like the practical piece and so it hearkens back to what NQF has proposed from the beginning which is let's just focus on three key behaviors and start identifying them, maybe one or two things that each system is going to do really well.

You know it's not going to be the universe of options and someone's going to say well why didn't you pick these 20 other sort of health improvement activities to focus on but I think if I've learned anything in quality improvement and changing the way systems think is you have to start small and build over time.

Paul Jarris: But you also have to have a conceptual framework and to me we - this will be successful if we create that conceptual framework where people realize that there are these interrelated systems, that each can bring something to the table.

And to be most effective we need to have the full spectrum of social determinants and health factors and clinical things brought to the table at the same time.

Typically if you put out a call for asthma you're going to get things around (sea flow) meter spacers you know rescue, you're not going to get the stuff about where's the built environment, where's you know social policy.

And so I'd love to see this thing basically create the conceptual framework where all those things come together to truly affect the health of a population.

Dawn Jacobson: Right, and just to clarify I don't mean start small by just picking clinical care measures. I mean just to really carefully think of if you pick a health improvement activity, if it influences 20 indicators, are you going to focus on two in particular?

It's just - I don't mean small in concepts, I mean small in you know what you're linking.

Matt Stiefel: It's Matt; it's back to the fundamental question though, is this a call for health improvement activities for population health outcome measures.

And I still think you can wrestle with that question. I wanted to suggest one thing for the paper, it's part of what we were talking about how caught up by how this system interrelates and I think that another Venn diagram would be useful in the paper.

You've articulated the clinical care delivery system and public health system and other stakeholders. I think a picture of that would be very useful and important and in that picture depict the overlap.

Obviously the public health system provides a lot of clinical care delivery and there's important influences in both direction to healthcare delivery system is doing more and more traditional public health activities.

And vice versa, so and then I think it's a way to bring in the other stakeholders too to show how they influence. But I just think that that's - it's rather than articulating three distinct groups talk about how those groups - more importantly talk about how those groups fit together.

Paul Jarris: Are there other points to bring up at this - anything else we can confuse Steve and Dawn with?

Matt Stiefel: Okay just - I just want to underscore that IOM framework is I think very useful in helping to understand determinants and causal pathway to intermediate and operational outcomes.

I don't think it's good for shedding light on what we mean by population health and even the paper spends a lot of time on that and I do think it's quite important and there's a lot of (unclarity) about what we mean when we talk about the health of the population.

I think that this distinction between physiology and disease and injury functional status and quality of life is - and how those fit together is an important part of our work here and ought to be clear in our model and I think in the call for measure.

Paul Jarris: So you know I think we may just have to accept that given all the groups over time including IHI and elements of HHS and now NQF and CMMI, no one has come up with a definitive definition that we probably can't expect that of ourselves.

Maybe the best we can do is - and (Bobby) I think you started this, take a couple definitions and combine them and say this work group put forth the following as a working definition, not proposing that we have the perfect definition.

I do think IOM is also struggling with this right now in one of their committees and I'm not sure when their report comes out but I think it's the primary care and public health committee.

Steve Teutsch: Just perhaps when we look at the model I think that's one of the things that I attempted to do is distinguish between those different levels of physiology, disease, injuries, functional status and well being.

You might want to think about how that fits in, not just the definitions but the framework.

Matt Stiefel: I would go one step further, I don't know which IM committee you're referring to, I'm on ((inaudible)).

The integration of primary care and public health maybe was struggling with this issue. And so they looked at a number of definitions and I think one of them was the Canadian was it a 2002 or '03 definition that was forwarded?

Steve Teutsch: Yes, I think the measurement report of that we referred to several times it actually talks about thinking of health and health measures, not only as the sum of the health of individuals and some overarching measures such as health related quality of life or however you want - whatever you want to go.

But also the whole issue of the fact that we need healthy communities and what are all of the dimensions that go into that which we sort of talked about here as the social and environmental determinants.

But part of the challenge here is building those healthy communities and having metrics for that as well as the health of individuals and the processes that go into the care of them.

And it's - we don't - we actually have a better job at the individual level than we have at the community level in terms of really good measures.

(Bobby): Steve and Dawn this is (Bobby), can I make a recommendation about recommendation number one? Which is rather than using the term total population health there that the concept and definition that it's really a concept and definition of a total population.

Because then then talks about who we're talking about and the concept of health then has to do with the model that we're trying to develop about how we'll know whether - how we'll know something about either a total population or a sub population and the contributing factors that lead ultimately to the outcome for either one of those two populations.

Dawn Jacobson: Yes that seems reasonable.

Elisa Munthali: Paul?

Paul Jarris: Please.

Elisa Munthali: This is Elisa; I'd like to open the lines up for member and public comments and so Sarah?

Paul Jarris: I think Elisa before we do that because I think we have that at 2:40 and we're at 2:20, we had in a prior section actually a discussion of the call for measures also and I don't think we specifically talked about that.

And I'm wondering if we can just pause for a second and especially in light of the conversation we're having think about how the call for measures can both inform and be informed by the paper that we just reviewed.

So I do think they're not quite synced just yet and they couldn't have been because the paper just came out.

Helen Burstin: They couldn't have been, right. And this is Helen and I think that's fine, I just wasn't sure other people who specifically wanted to give paper input but we can gather that together.

So again we really want to thank Steve and Dawn for really producing a great product and I'm glad the committee has made even more suggestions to help improve it even more.

We did ground the call for measures in what we knew so far we did not have the benefit of the paper, we'd be delighted to have Dawn and Steve's input as well as anybody else into the call for measures.

We tried to as much as possible go back to the national quality strategy specifically pulling in the three tiered approach to population health that was there.

Again we are NQF so we're trying to stay - we want to stay as broad as we can but at the same time I think staying within the context of the broader quality strategy fits for us and I think those three goals still seem to work.

I think we very much have done the clinical preventative services in phase 1 and so we are very much left with more of the focus on those healthy behaviors, well being as well as those community interventions that affect determinants.

So when we drafted this and I drafted this one of the - I think one of the things we struggled with and it was a great discussion today was this issue of where is the locus of accountability, just to be clear NQF endorsed measures are intended to be used for both quality improvement and accountability.

So I found some of the initial discussion and framing about clinical and governmental public health and others very helpful.

We may need to reframe the way this is drafted but we did specifically say here that we are most interested in measures that are community and population level performance measures.

So that was intentional to try to keep the more clinically oriented measures I think outside this project although certainly open for discussion about how they might be complementary.

And then one of the things I did try to include in here and Paul and Kurt helped with this was you know what is the accountability level and at least what we said here was appropriate for community healthcare system and multi stakeholder accountability and that's certainly something I think we'll need to take a closer look at in light of the discussion today.

We left a broad set of bullets under that, really trying to look at behaviors, determinants, community interventions that lead to improvements.

And again I think it was Dawn who raised the question of you know are we going to be doing a call for improvement strategies and you know not unless it could be couched as a performance measure with a clear accountability I think as a process measure or something along those lines.

We did try to be as broad as we could looking at the framework we had from Matt and did specifically include the outcomes including health benefits and quality of life.

And try to you know contextualize that it's both a population who may share an identity or a geographic proximity and we did emphasize the life span.

One of the things that I think we could use some help with is we did indicate as well the priority areas that we initially discussed with HHS, overweight, obesity, physical activity, tobacco use and nutrition and I guess one of the questions I think for all of us is if we're going to stay broad in terms of describing the framework, is it a way for us to somehow prioritize this initial foray into population health so that we don't get deluged with more measures than I think you'll be able to handle.

We then did include the small footnote making the point that we do also have this project currently ongoing on healthcare disparities and culture competency.

I did just confirm that about a dozen measures were submitted all of which were clinically oriented so I think the broader population health perspective on equity is very much fair game in this project.

And we also have a behavioral health project where some of the more clinically oriented measures, hospital, individual physician, another provider level measures on tobacco use, alcohol and substance use will be there.

So again we've tried as much as possible to allow this committee to stay at the population health level for this next phase of work, but I think one of our real challenges and I think where we'd love to have the input of the committee today or when you had a chance to really look at the paper and this together, you know what are the - what's the right levels of accountability, how do we make it broad enough to be respectful of what we recognize to be an incredibly broad and rich framework for population health.

But make it something that is perhaps something we can accomplish in this initial project. You know for example I was intrigued by Dawn and Steve's paper, the concept of 3450 as being something to kind of wrap your hands around that at least I think would potentially allow us to focus on some of those initial prioritized areas but still get to outcomes as well and equities.

So I'm going to stop talking and just take input but again keep in mind this is very much a four year reaction and again I think it will be heavily informed by this discussion but also the great work we've seen from Dawn and Steve.

I'll turn it back to you Paul.

Paul Jarris: Thanks so let me open it up to the group for any general comments or specific comments.

We have about 15 minutes for this section right now.

(Bobby): Hey Paul it's (Bobby).

Paul Jarris: Go ahead (Bobby).

(Bobby): Yes can I just walk through it from top to bottom and just make a couple of comments about sections as I made notes?

Paul Jarris: Yes and what I might suggest is it sounds like you've done a thorough review, if you want to hit the highlights and then email to us the more specific corrections that might be the most efficient use.

(Bobby): Okay let me try to do that. One highlight is what was either left out or was inconsistent in the population health measure evaluation column was a focus on quality improvement which was in the evaluation criteria for clinical measures.

And so I think that consistently throughout the population health measure evaluation the idea of quality improvement is also important to include.

And I think it gets back to the discussion about efficiency and effectiveness as one reason for thinking about quality improvement in the population domain, in the population measure evaluation criteria too.

I think that in Section 1A where we're referencing certain national prevention strategies good idea to reference the other national work like the community benefit work that is underway.

And then down in 1B, because of the discussion we just had the idea of including notions of process and strategy in that area is important.

Helen Burstin: Just one quick question; it sounds like you're actually going through the measure evaluation criteria and guidance. We were mainly focusing on just the call for measures for today although we'd be delighted to have any feedback on that as well.

(Bobby): Oh okay.

Paul Jarris: Okay so (Bobby) why don't you consider from that you brought up some - whatever issues you have that ought to be concepts in the call for measures would be important.

And I think - and Dawn you brought up something earlier about linking the measure to ultimate outcome from a logic model approach.

(Bobby): So we're just looking at that first - just that three page?

Paul Jarris: Yes, for now.

Matt Stiefel: So it's Matt, I wanted to comment on that logic model as well, some specific suggestions, one is I think that carrying into the call for measures from the paper, the distinctions of definitions of determinants, health outcomes and improvement activities.

And I actually think we have some choices to make because they just kind of provided us with the negative. And then being explicit in the call for measures as I mentioned about where the measures fit in that framework.

And building on Dawn's suggestion if there are measures of determinants or improvement activities I think it's incumbent on the proposer to talk about what is the measure of population health that they're ultimately attempting to ((inaudible)).

I don't think it's sufficient to submit - I mean at least from my perspective - a measure of tobacco use as an example of even the one that's encouraged.

So we get a proposal for a measure for tobacco use, that's not a measure of population health, it's an important determinant, behavioral determinant influenced by upstream practices.

But I think we need to force using the framework to say and that will have an effect on one of the components of what we mean by population health, either disease status or mortality or morbidity or well being in the population.

Paul Jarris: You know Matt I think you make an important point but one of the other things to just take the simple example of you know a tobacco measure, whether it's the rate of tobacco or you know rates of tobacco cessation or whatever, NRT treatment.

Is that if we have an NQF endorsed measure then that can be used by CMI to hold accountable care organizations accountable for tobacco, not just for treating disease well but for what are the rates of tobacco smoking in their population and the quit rates and successful rates.

So what that does will align the accountable care organization and clinical medicine with the public health notion that we need to decrease smoking in the population and therefore incent the accountable care and as a clinical sector to actually start looking upstream at initiation of smoking and quitting smoking.

So to me that's a very important thing to do, even though it may not be the most satisfying measure. It aligns incentives.

Matt Stiefel: But what I'm saying is yes, that's important and I would push even further to have a tobacco use measure.

But I think for it to become a population health measure it's also incumbent on that accountable care organization to be measuring mortality and lung disease and other downstream health outcomes associated with that behavior.

Paul Jarris: Okay.

Mike Soto: I was thinking that the point was if somebody's proposing a measure of smoking they need to make clear how that's related to population health outcomes as part of the justification, just as you would a process measure for a clinical preventive service.

Paul Jarris: Right.

Helen Burstin: And that's really something that - this is Helen that we can go back and take a look at the evaluation criteria, we can certainly weave some of it into the evidence to support the measure focus section.

Matt Stiefel: And I guess that begs the question about who measures the outcomes again because I think it's a big problem with health systems now is that we tend to not measure some important things like mortality.

Mike Soto: well you know one of the challenges about applying the NQF framework to population health is that the NQF process really looks at one measure at a time.

And I think that you know we recognize that we really need to look at kind of the whole spectrum of measures in the population health framework and maybe that point can be made more generically.

Male: That was the discussion we had earlier this afternoon.

Paul Jarris: Well I have a nit picky thing, the second sentence population health not only focused on diseases across multiple sectors, and perhaps it may focus on disease but hopefully it focuses on health and well being across multiple sectors.

The disease orientation exclusively bothers me a little bit, so that might just be a small editing issue. One other thing I want to say about the population measures and the following priority areas are encouraged, certainly these are important underlying causes of illness and death, overweight, obesity, physical activity, tobacco use, nutrition, but they also are often - and I've had

the experience of doing public health clinical meetings in which I've been told by the clinical sector well overweight and obesity aren't our issue in the clinical sector.

That's an issue for you public health people. So you know it's important that it's there, but I think there's other low hanging fruit that isn't included here such as - and the national priorities partnership has picked maternal outcomes particularly with pre-term delivery as a area to focus on.

And I think those - you know prematurity and infant mortality is something that clearly cuts between population health and clinical medicine and can't be solved by either alone.

So to pick an example like that which so clearly brings together issues around public policy and hospital policies and community resources and clinical practice and payment methodologies and data and information would be I think important to call for.

Sarah Sampsel: Hi if I can start, this is Sarah Sampsel I just ((inaudible)) real quick, I really support as well as on the breast feeding and early ((inaudible)).

Paul Jarris: Sarah, maybe you could pick up the handset, there's a lot of echo.

Sarah Sampsel: Yes, sorry about that, I think my phone is dying. But I think - so I really support the maternity concept but I would also support the early infant care concept and that's really what I felt was missing in that priority area.

Paul Jarris: Would infant mortality capture both or maternal...

Sarah Sampsel: Well I guess we at WellPoint call it maternity and infant health or you know kind of pull it all together because there are so many areas of that not only prenatal but post natal care that are essential for the life and development of that child.

So as an example breast feeding programs and breast feeding measurement is kind of a huge issue right now in looking at childhood obesity.

(Madeline): I would also like to reinforce Sarah's point because it helps us touch a little bit on the mental health component which you get in talking about care of the newborn, that early maternal child piece. We don't really get to in a lot of other places.

And so it's about what those into the care that really does affect the outcomes which - and the inputs being other than nutrition right? So it gets at a more complex idea in describing the kinds of measures that are going to look beyond the most obvious measure that we can measure concretely.

Helen Burstin: Paul this is Helen, I just want to follow up on this concept of the maternal health stuff, this is a great example of where - how this work relates to our other work as really we'd really welcome input from the committee.

So we've got a perinatal health committee that has already endorsed that measure of preterm delivery, we already have a measure of low risk birth outcomes and low birth weight.

Again they're very oriented to the provider level and so I think the challenge for us is going to be do we craft this call in some ways to say don't bring us those, somehow bring us the ones that are not so clinically oriented where we've already got them.

But they would be companion measures.

Paul Jarris: That's the problem when we hear - and I'm not saying from you but we hear it in many other areas including when we launched our Healthy Babies initiative initially we heard from the maternal child health people, we're already doing that.

Wait a minute, there's a whole lot of stuff you're not doing and that's what we're looking at. So if there's a way to craft it in that way there's some very - I mean the hard stop policy in the hospital is important. But the you know changing Medicaid and private payment for pre-term birth is a hugely powerful lever that often isn't looked at when you're looking at the clinical solution, so...

Helen Burstin: Right, I guess the question would be is that a performance measure and if so at what level of accountability?

Male: Well I think you can avoid this stay if the measure is preterm birth or infant mortality and see the set of interventions is vast.

Paul Jarris: But I guess the question, how do you broaden those interventions beyond just the clinical sector? For example I mean you know several states now Medicaid no longer pays for a non-medically indicated induction or section before 39 weeks.

Which means working with the doctors but it also means working with the community to affect in the community demand among the consumers for such things, so you know if there's a way to perhaps frame it so Helen maybe it's said in addition to existing measures, other measures that reflect population health intervention for ((inaudible)).

(Madeline): Yes maybe we even need to say excluding clinical interventions or excluding direct provider interventions because getting at these other broader concepts is not going to be easy for a lot of people.

Paul Jarris: What we wouldn't want to do and we're trying to bring the two sectors together so we wouldn't want to excuse them from working together.

So if they submitted five measures and three of them were already endorsed clinical measures, they would just get that feedback.

Okay, we'll look at these other two.

Helen Burstin: Okay. And that's why I was suggesting earlier you know one possibility may be as they bring these measures in can they identify what measures are already being used in the clinical sector that would be complementary.

Paul Jarris: Right.

(Madeline): Right, or derivatives.

Male: Why would a clinical intervention to reduce preterm birth be a population health measure?

Paul Jarris: It's part of the systematic change. I mean my version of public health is that we look at a systematic sustainable change which means that you're looking at public policy, you're looking at community development resources, you're looking at patient education and self management, you're looking at clinical sector, you're looking at information systems, data and information systems to drive change and you're looking at payment.

And if you're going to systematically take an issue on so that it lasts more than a grant or a project, you've got to affect multiple areas across that six spectrum levers for it to be sustainable.

And the study of Wagner's, I think it was Rand did a study of the early diabetes collaboratives, you know that didn't include the public policy aspect.

But they found that the only ones that had sustainable change affected at least three components of the system. So clinical interventions are absolutely part of a comprehensive public health intervention.

Dawn Jacobson: This is Dawn; I know it's not common to use the accreditation domains from the public health accreditation board which are the tenants central public health services but there may be a way that you can put in the call for measures that Figure 2 from the commissions paper, to really direct people that we're looking for things other than essential services seven which is healthcare services part.

But those ten essential public health services are ((inaudible)) set in plain language.

Paul Jarris: This is where that Figure 2-1 that IOM one I think is so good because it shows a broad spectrum of potential interventions which should suggest measures. And the one above it, 2.2 shows you know the different levels, whether it's a process and policy versus intermediate versus health outcome.

Dawn Jacobson: And you could draw arrows or color the boxes or whichever one - you know to pull attention, draw people's attention to what you're looking for.

Male: Dawn I like the idea of the ten essential public health services and saying that we're not interested for this call in the clinical one. Not because I don't think they're important in the way that Paul described but because we're probably more likely to get those unless we exclude them.

(Crosstalk)

Male: Linked in the way that we were with other measures in the way that we talked about earlier.

(Madeline): but I think being as clear as we can be about that is also educative to the group that we want to submit. Because we are in new territory and I think we need to be as explicit as we can be and give examples so that people get the idea.

And while it seems a little pedantic, I think at this point in time it would be necessary.

Paul Jarris: Well it's important because the folks who are familiar with the NQF process and is submitting to them out of the clinical people and so we do have to inform them that this is a little bit different as well as people who aren't familiar with the NQF process.

(Madeline): Yes.

Paul Jarris: Other comments in the next four minutes? Actually we're almost - other comments?

Helen Burstin: Paul I should have - this is Helen, it would be great if people want to mark up or send anything back on paper as ideas of how to reframe this, we'll also take a look at the paper. We welcome Dawn and Steve's input.

But you know we are still at the point where you know this is such a bit of a departure for us that we've actually been having some discussions with Janet Corrigan and other sort of leaders in this field to try to figure out where is the logical kind of line of where accountability sort of still fits, has some potential relation to the example you gave earlier Paul about you know CMMI and ACOs.

But wanting to be respectful of wanting to go to what you all view as important is going to be key. So we're actually going to go forward as soon as we get a sense from you of what this call for measures looks like.

And actually bring it up through our consensus standards approval committee and board even before we go out, just feeling like we want to make sure we've really got consensus that this is the right space and how broad we can be.

Paul Jarris: Helen we need to have a conversation about that term accountability because I know that's come up in the NPP and there are clear accountabilities in public health that are different from the clinical accountabilities.

And I often found that in that meeting the clinical people say well no one's accountable in public health and I won't start my diatribe about the number of times I was almost fired for these reports.

Helen Burstin: No and we'd love to have that discussion and I don't think people would argue that as long as there is an entity accountable that would be fine. I think the issue is for some of the particular determinants completely outside of you know our usual domains, I think that's where it gets a bit trickier.

We can certainly - we'd love to talk that through and you know committee members or the authors have any thoughts about that we'd really welcome it as well.

Paul Jarris: Okay, any final comments before we go on to the member and public comment section? We wore everybody out? Okay. Elisa did you want to take the next step?

Elisa Munthali: Sure, operator?

Operator: Yes, ma'am.

Elisa Munthali: Yes, could you please open the lines for anybody who might be on that wants to make a comment?

Operator: Absolutely. Please press star then 1 to the audience if you have a question or comment at this time. We'll pause for just a moment.

And it appears we have no questions at this time.

Elisa Munthali: Operator, do you know if Peggy Honore signed on?

Operator: I can certainly check, just one moment please. Yes Peggy is on and Peggy your line is open.

Peggy Honore: Okay, thank you very much. I also wanted to echo an observation I don't remember exactly who said this but on the (sea fold) population health diagram I too had a concern that medical care was highlighted and had its own area of focus.

But it seemed to be lacking a focus on public health but I think that the conversation was very rich on that topic today so that's my only comment on that.

My other question is on regarding page 38 of the environmental scan paper, there's a note on here about future opportunities and it mentions under quality performance and reporting if Dawn or someone could address exactly what the intent is with that, that would be appreciated.

Dawn Jacobson: This is Dawn; I can answer that Peggy. Right now the - everything preceding the concluding section is really just laid out measurement and indicators and what's most commonly

prioritized and how we should you know put them in the context of the different systems and subsystems.

And I would really like to at least have a section that talks about how are we going to use this one if we pick them, you know and I'm not as familiar with NQF and the reporting procedures.

But you know ideally if this is the first group that's going to really integrate the two and have a shared you know set of complementary measures there should be a way that we would be reporting that or that others could do something similar.

And so I just wanted to make sure that that was included as sort of an opportunity going forward and then I do think the work that's been done within the public health quality improvement work at HHS really has already integrated that.

It's taking the six domains or areas of quality that were really for the clinical care system and then it was broadened and I think there's a way that those can be merged and that reporting should happen across the country going forward.

Elisa Munthali: Are there any other comments?

Paul Jarris: Operator, any...

Operator: We have no further questions in the queue.

Paul Jarris: Elisa did you want to review the next steps?

Elisa Munthali: Yes, thank you very much, Paul and thank you everyone for the discussion today. I will briefly go over the next steps, Helen did mention some of them.

First was the commission paper, Steve and Dawn will go back and incorporate your feedback on the first draft and then following that we will post the paper to our website for a 15 day comment period.

And then after that, we will schedule a call with the committee to discuss the comments that we've received and any responses to those comments.

We're trying to schedule that call and we'll let you know, Kristen or Sheila or I will be in touch with you. And following that meeting we'll post a final paper to our website.

With regard to....

Paul Jarris: Elisa is it possible to put a day or two between the return of the edited paper and it going on the website for the committee to look at?

Elisa Munthali: Yes, absolutely. We'll have a period when you can look at it before we post it to the web. Any questions on the commission paper? So with the call for measures as Helen noted we as staff will also incorporate the comments that we received from you and of course this is a working document.

Helen also mentioned that we want to get the CSAC and our board engaged in our discussion early on.

And so we'll be going to them and so after we hear from them and they give us some guidance on where we're going with the call for measures we'll post it to the NQF website.

Of course in between that period, we'll share whatever feedback we have from them and ask for your comments on the call for measures.

And then we'll post it to the website and then you know as this process is going on, we're hoping that we can work with you to continue to outreach to a broader population health community.

So you'll be hearing from us definitely and I think that's' it Helen, did we have anything else?

Helen Burstin: No, I think the only thing I would say is if anybody has any specific thoughts about what measure that are out there would be potentially applicable, we'd love to just sort of alert those developers that the call's going to go out in the next month or so just so they're aware of it and the more time we give them the easier it is for them.

So if anybody has any specific ideas about some developers we should at least be in contact with to make sure they're aware of this process.

We'd be happy to do so.

Paul Jarris: And I know Peggy if you're still on something you can discuss at HHS as well as Kathleen from her ((inaudible)) and Sarah from hers.

Helen Burstin: Definitely.

Mike Soto: So you're still looking for comments on the guidance too right?

Helen Burstin: Absolutely, comments on any of the materials we sent you last week or this week please we would very much welcome those. We don't want to try - I mean we really put that call for measures out there just to have a strawman for you to react to.

So we would very much love your comments on it, we recognize you're the experts, that's why we have this extra panel so we would love to have your input on that.

And we will share the additional groups around and we do have a Sharepoint site as well.

Elisa Munthali: We do, I was going to ask about that, have you all been contacted by our colleague Connie Bach? Okay so we're hoping that with the volume of work that we have and the document sharing to post these documents on there and to get our online forum established so that we can have conversations through Sharepoint.

I think it will be a lot easier to do that than doing it over email.

Paul Jarris: Can you resend that information please?

Elisa Munthali: Absolutely.

Helen Burstin: We'll take care of that and we'll also let you know exactly which documents are posted so that you can pull down and review anything you'd like and share your comments.

Because I think obviously we've come a long way and really want to thank Dawn and Steve again and Matt certainly for all the pre-work but we'd love to really get your input as we kind of try to think carefully about launching into where I know you all really want to go which is the next phase of work.

Paul Jarris: When is the CSAC meeting and is that something that you and Elisa go to or do Kurt and I go to that also or how does that work?

Helen Burstin: Yes so the consensus standards approval committee meets in person in March but has a call in mid-February. I actually run it, I staff it so I'll certainly be there and we would very much invite you and Kurt to join in on the phone or in person as they have that discussion.

I just want to be able to share something with them that you all feel comfortable is ready to be shared. And we'll also - I think we're thinking of having - the board will have a conference call in I think it's late march and we'd love to get you know you engaged in that discussion as well.

But I think a lot of this can be done just really trying to get some clarity in some of these documents, will just make it so much easier to share with them since they will know much less about this area than you do.

Paul Jarris: Okay any questions or comments from the committee?

Female: Sorry I was late.

Paul Jarris: Life overtakes us sometimes, but thank you everyone for your participation and Steve and Dawn we look forward to hearing more from you and please feel free to give us a call if we can help in any way.

Steve Teutsch: Well thanks very much for all your help.

Paul Jarris: Thank you.

Operator: And that concludes today's conference, we thank you all for joining us.

Female: Thank you Sarah.

Sarah Sampsel: Thank you, bye bye.

END