

NATIONAL QUALITY FORUM
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POPULATION HEALTH ENDORSEMENT MAINTENANCE
PHASE II
STEERING COMMITTEE MEETING

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THURSDAY
MAY 31, 2012

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The Steering Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Paul Jarris and Kurt Stange, Co-Chairs, presiding.

PRESENT:

PAUL JARRIS, MD, MPH, Co-Chair
KURT STANGE, MD, MPH, Co-Chair
RON BIALEK

MADELINE NAEGLE
ROBERT PESTRONK
SUE PICKENS
AMIR QASEEM
SARAH SAMPSEL
JASON SPANGLER
MATT STIEFEL

MICHAEL STOTO

NQF STAFF:

HELEN BURSTIN, MD, MPH
KRISTIN CHANDLER, Project Analyst
ELISA MUNTHALI, MPH, Senior Project Manager
for Population Health
ROBYN NISHIMI, NQF Consultant

ALSO PRESENT:

PETER BRISS, CDC*

IAN CORBRIDGE, HRSA*

PEGGY HONORE, Office of the Assistant
Secretary

for Health, HHS

DAWN JACOBSON, Public Health Institute*

LORRAINE MAINO-FIKE, Moderator

NEIL MAIZLISH, California Department of Public
Health*

*Participating via teleconference

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8:39 a.m.

CO-CHAIR JARRIS: Good morning, everyone, to Day 2 of our Population Health Work Group Meeting. And we had a long and tedious and productive day yesterday. In many ways, I think it really laid out a lot of the issues we want to discuss in depth today. And today we'll have, first of all, a little bit of review, a recap that Elisa can do of yesterday. And I think it should be actually a fairly interesting and engaging day today. We have a facilitated conversation to look around some of these issues, to look at:

What have we done to date?

What's going well?

What hasn't gone well?

We'll hear from a couple of representatives of the measures community to talk about why they think we got the response we got and not a different response, how is that field in terms of their receptivity to an

1 NQF process as well as their readiness for it.
2 And from that, hopefully we'll be able to
3 develop some common sense of a path forward;
4 recommendations, what can we do to improve the
5 field, improve the response to the call to
6 measures and also consider some more about
7 what some people raise as a round peg in a
8 square hole or a square peg in a round hole,
9 however that goes, and, you know, whether the
10 peg is right and the hole is right. So, how
11 we can modify that process.

12 So, I think it should be an
13 interesting day and really get us back to the
14 reason lots of us here is to try to develop
15 this field of population health measures that
16 can be applicable and ultimately drive
17 improvements in the health of the population
18 that are being served.

19 So, anyone else want to make any
20 opening comments? Okay.

21 Elisa, did you --

22 MS. MUNTHALI: Thank you, and

1 welcome back.

2 I just wanted to remind everyone
3 that, you know, the meeting is being taped and
4 transcribed so please remember to speak into
5 the microphones.

6 Before we start our discussion
7 today we wanted to recap what happened
8 yesterday. And, as you know, the Steering
9 Committee evaluated and voted on nine
10 measures. There were four endorsed BMI
11 measures, some clinical BMI measures and five
12 newly submitted measures, one of which was
13 clinical BMI measure. And of those, the
14 Steering Committee has recommended three.

15 The first measure is Measure 1999
16 which is the late HIV diagnosis. It's a CDC
17 measure. It's a newly submitted measure to
18 the project.

19 The second measure is Measure 0029
20 counseling on physical activity in older
21 adults. It's a two part measure. The first
22 part is discussing physical activity and the

1 second part is advising on physical activity.
2 It's an NCQA measure which was previously
3 endorsed.

4 And the final measure is 0421
5 preventative care and screening: BMI
6 screening and follow-up. A CMS measure also
7 previously endorsed.

8 There were five measures that were
9 not recommended for endorsement.

10 The first one is 2014 place of
11 birth, a CDC newly submitted measure.

12 The second is 2018 year of arrival
13 to the U.S. for the foreign born. Also CDC
14 newly submitted measure.

15 0023 is a BMI measure for adults
16 18 and older from the City of New York,
17 Department of Health and Mental Hygiene. That
18 was also previously endorsed.

19 1690 is adult BMI assessment, NCQA
20 a newly submitted measure.

21 And 0024 BMI for children age 2 to
22 18 years of age. That was a previously

1 endorsed measure from NCQA.

2 The Committee has held voting on a
3 newly submitted CDC measure. I'm sorry.

4 MEMBER SPANGLER: Elisa, I thought
5 0024 was passed yesterday.

6 MS. MUNTHALI: Okay. Sorry about
7 that.

8 MEMBER SPANGLER: Okay.

9 MS. MUNTHALI: So just a
10 correction. 0024, the BMI measure for
11 children age 2 to 18 was passed. That was
12 recommended by the Steering Committee. This
13 is an NCQA measure that was previously
14 endorsed.

15 The Committee has held voting on
16 2020. This is adult current smoking
17 prevalence. It's a CDC newly submitted
18 measure. They had several questions for the
19 developer who was unable to attend. Staff has
20 been trying to reach them and we can't get a
21 hold of them. And so we do have some concerns
22 with this measure.

1 We wanted to share with the
2 Committee that just prior to this meeting just
3 last week the developer -- the staff developer
4 at Legacy left. And so I think some of this
5 turnover is probably indicative of them not
6 being able to attend the meeting yesterday.
7 So we will let you know what we can do in a
8 way of working with Legacy. We've spoken with
9 Ron and Ron is going to help us as well to
10 reach out to them.

11 So before we start the facilitated
12 discussion on trying to improve future
13 response to call for population health
14 measures, we want to give you some background
15 information on the recent call for measures.
16 This discussion was to take place yesterday,
17 but we ran out of time. So, we won't take too
18 long but much of this information you've heard
19 before.

20 The call for measures, as you
21 know, was developed by the Committee with
22 input from NQF staff. What we tried to do

1 with the call is integrate priority areas for
2 healthy living and well-being from the NQS and
3 the NPP with a focus on community
4 interventions that result in improvement of
5 social, economic and environmental factors and
6 interventions that result in adoption of
7 health lifestyle behaviors across the life
8 span.

9 The call was also informed by the
10 Commission Paper on Population Health. Sorry.

11 MEMBER STOTO: I'll ask you what
12 NQS and NPP are.

13 MS. MUNTHALI: The National
14 Quality Strategy and the National Priorities
15 Partnership.

16 MEMBER STOTO: Okay.

17 MS. MUNTHALI: Sorry about that.
18 I'm so used to acronyms.

19 So the call was also informed by
20 the Commission Paper on Population Health
21 which was written by the Los Angeles
22 Department of Public Health and the Public

1 Health Institute. And in that paper the
2 authors presented an environmental scan on
3 existing population health measures and
4 provided gap analysis, but they also provides
5 conceptual frameworks for measuring population
6 health, the determinants of health and
7 improvement activities.

8 It took several months to finalize
9 the call, and this was due in part to the
10 delay in the paper development. But we felt
11 that it was important to wait for this work
12 because it was informative to developing the
13 call. And since this was the first time that
14 NQF had put out a call on population level
15 measures we wanted to make sure that we
16 received input and suggestions for refinement
17 throughout the entire development process.

18 And so we got input from our Consensus
19 Standards Approval Committee, which is a
20 standing committee of our Board. So the call
21 was finally posted in early April for 30 days.

22 Outreach was conducted prior to

1 and during the call for measures. The
2 Committee played an important role in our
3 outreach efforts. Just prior to posting the
4 call the Co-Chairs forwarded the draft call
5 for measures to external partners to gauge
6 their thoughts about the call: Did it make
7 sense, was it relevant to their work?
8 Committee members also arranged meetings with
9 potential submitters like Ron arranged a
10 meeting with us and Legacy.

11 They also put in a plug at your
12 individual meetings, during external webinars
13 and other fora.

14 As we do with our other consensus
15 development projects, particularly in new
16 areas like population health, NQF made sure
17 that the word got out about the call through
18 monthly webinars, developer webinars, our
19 member Council meetings, member communications
20 like our member blasts and alerts, one-in-one
21 calls that we had with developers in meetings
22 and our leadership. Helen and Janet met with

1 our external partners to tell them that this
2 call was coming up.

3 And with regards to the response,
4 we had several calls and many email exchanges
5 with potential submitters. There was a lot of
6 interest and enthusiasm, a lot of people
7 thought we were moving in the right direction
8 putting out this call for population health
9 measures. But as you know, we received just
10 five measures and one of which was a clinical
11 BMI measure. But we've been very fortunate
12 through this process that potential developers
13 have been extremely forthcoming with the
14 reasons why they didn't submit. And these
15 included concerns about their testing
16 completeness uncertainty, about testing
17 requirements. And where we heard this we made
18 sure that we held calls with our
19 methodologists on staff with the developers to
20 determine whether or not they had the testing
21 requirements.

22 Many of them cited a lack of

1 resources. It could have been with their own
2 staffing or the time to gather information, or
3 to complete the submission form, or a testing
4 of their measure. And then some of them cited
5 competing priorities.

6 I mean, there are some that wanted
7 to submit to the project but perhaps were
8 thinking they could submit their proposal or
9 their measure for publication.

10 And so I think you have the
11 outreach document. Kristin is going to share
12 that with you, but it was included in your
13 briefing materials for this meeting. And we
14 just wanted you to look at that.

15 We've been noting all of the
16 communication that we've had with developers
17 and so you can get a sense of who we've talked
18 to, some of the reasons that they've cited in
19 greater detail.

20 And so that's it for me. We're
21 waiting for our facilitator.

22 DR. BURSTIN: She's parking.

1 MS. MUNTHALI: Okay. Great.

2 CO-CHAIR JARRIS: Any questions or
3 comments? Ron?

4 MEMBER BIALEK: I do have one
5 question, which is the implication of us not
6 endorsing the measure, especially a measure
7 that had previously been endorsed is there any
8 implication?

9 DR. BURSTIN: We do it all the
10 time.

11 MEMBER BIALEK: Okay.

12 DR. BURSTIN: So we do it all the
13 time. In fact, as we've raised the bar on
14 endorsement many of the measures endorsed
15 three, four, five years ago are not being re-
16 upped for endorsement. The implications are
17 sometimes if they're a national reporting
18 programs, they need to be eventually pulled
19 out of those programs, retired; that usually
20 happens over a period of time. But beyond
21 that, no.

22 CO-CHAIR JARRIS: And also is can

1 you explain the appeals process? Because the
2 NQS folks yesterday indicated they may appeal
3 our decision on the BMI, which is fine because
4 we don't have the full perspective of all
5 these measures and I think that's what an
6 appeals process is for.

7 DR. BURSTIN: Right. So there's
8 two kinds of appeals, one of which is a
9 measure makes it all the way through, at the
10 end of the process anybody can appeal saying
11 "Hey, one more time," as just happened with
12 our hospital wide all cause readmission
13 measures, the bane of our existence for the
14 last six months, just got appealed. So at the
15 end of the process anybody can say still I
16 don't agree with the process, it should have
17 been no.

18 On the other hand if it's during
19 the course of a project and the Steering
20 Committee does not recommend a measure, they
21 have the option of getting a second opinion
22 from the CSAC, which is what they'll do where

1 they're review the process, review what the
2 ratings and criteria were. They rarely
3 overturn what Steering Committees do. They
4 don't like to redo Steering Committee
5 business. They really just make sure their
6 process was followed, the criteria were
7 appropriately met or not met.

8 CO-CHAIR JARRIS: Other questions?

9 Perhaps we could, two options. We
10 could just take a minute to look over this
11 measure of developer outreach if people
12 haven't digested that. The other thing we
13 could do is just get started with Peter and
14 Neil.

15 Peter and Neil, are you on the
16 line?

17 Operator, could you check if Peter
18 Briss and Neil Maizlish are on the line?

19 OPERATOR: And that is Peter -

20 DR. BURSTIN: Peter Briss and Neil
21 Maizlish.

22 OPERATOR: Okay, thank you.

1 CO-CHAIR JARRIS: While we're
2 checking on that, Peggy did you want to at all
3 address the group about some of the work
4 you're doing with CMMI? We're putting you on
5 the spot, so if you're not ready, that's okay.

6 So Peggy Honore is going to come
7 up from Health and Human Services the Offices
8 of the Assistant Secretary for Health and talk
9 a little bit about the work that she is doing
10 as she has detailed some of her time to CMMI,
11 Center for Medicare and Medicaid Innovation.

12 DR. BRISS: Hi. This is Petter
13 Briss. I just wanted to let you know that I'm
14 here.

15 CO-CHAIR JARRIS: Okay. Peter,
16 we'll get to you right after Peggy then.
17 Thank you. And you and Neil, thanks.

18 MS. HONORE: Thank you, Paul, for
19 inviting me to speak tot he group this
20 morning.

21 Yes, I am working in the
22 population health arm of the Innovation Center

1 in CMMI. The population health work is really
2 in its infancy at this point in time. We are
3 beginning to look at population health
4 measures. But I can tell you one of the
5 biggest barriers that I see, and others also,
6 is for the clinical side of healthcare to
7 really embrace and understand the concept of
8 population health. It's been very difficult
9 at times articulating and coming to a common
10 or consensus on exactly what is population
11 health and how it actually relates to the work
12 of clinicians. That's something that they are
13 rigorously working on by having a series of
14 webinars and listening sessions, especially
15 with the group of pioneers at CMS. So, it's
16 just going to be a process that,
17 unfortunately, we're going to have to go
18 through that impacts probably the low response
19 rate that we see here with this call for
20 measures.

21 You know, there's even confusion
22 over whether or not it's even a legitimate

1 concept of population health, believe it or
2 not. Those of us who work with this all the
3 time understand it and the leadership at CMS
4 certainly understands it as well, but it's
5 pushing that out and getting others to embrace
6 the usefulness of this.

7 So, that's an overview.

8 CO-CHAIR JARRIS: I understand the
9 work on population health measures is at this
10 point, sort of in limbo and on hold. Can you
11 let us know the status of what that is?

12 MS. HONORE: Well, it's not
13 because there isn't strong interest, but it's
14 because you know there's so many other
15 initiatives going on in the Innovation Center
16 such as, you know, the challenge grants and
17 some of the grants that will be coming out
18 soon. I'm really not at liberty to talk in
19 detail about those, but there will be some
20 things coming out. So it's just that the
21 attention has been split in so many
22 directions. And it isn't that work has

1 totally stopped, but those of us who have been
2 working on population health have been busy
3 looking at some other things.

4 So I would expect in the short
5 term that work will pick up again on that, and
6 perhaps I can even suggest to Jim Hester that,
7 you know a visit with this group or
8 conversation with this group could be helpful.

9 I know Matt Stiefel has provided
10 tremendous input that has been very well
11 received by CMS. So, that's one way that this
12 group has had involvement and engagement, but
13 I think perhaps you know I could suggest to
14 Jim that a broader conversation of this group
15 as well.

16 MEMBER STOTO: I just wanted to
17 clarify. You were talking about population
18 health measures within the CMS Innovation
19 Center, is that --

20 CO-CHAIR JARRIS: Correct.

21 MEMBER STOTO: Okay. Thank you.

22 CO-CHAIR JARRIS: As a measure

1 developer. Since we're not a measure
2 developer, we're a measure endorser, or not.

3 CO-CHAIR STANGE: Peggy, is there
4 anything interesting happening talking about
5 the denominator for accountable health
6 organizations and looking at accountable to
7 who and any work looking at ACOs actually
8 having accountability for the health of a
9 local community?

10 MS. HONORE: I'm not intimately
11 involved with the ACO activity. There is, you
12 know a lot of ongoing continuing dialogue. I
13 couldn't tell you specifically to answer your
14 point. But there is a lot of dialogue and I
15 would suspect that that will continue.

16 CO-CHAIR JARRIS: Any other
17 questions for Peggy?

18 Peter and Neil, if we could hold
19 you one more minute.

20 Facilitator, are you --

21 OPERATOR: To ask a question press
22 star and the number one on your telephone key

1 pad.

2 CO-CHAIR JARRIS: I'm sorry,
3 Operator. We actually weren't asking for
4 public input at this point. We were just
5 discussing with our facilitator whether she
6 was ready.

7 Peggy, do you have any advice or
8 feedback for this group based on what you've
9 been observing?

10 MS. HONORE: I've been very
11 impressed with what I've seen the last two
12 days that I've sat through the meetings. You
13 know, I would just like to say that you know
14 I know that there was a low response rate, but
15 I think that this barrier with getting people
16 to understand the concept of public health --
17 I mean of population health is probably a
18 bigger barrier than anyone here probably
19 initially realized. But the concept of
20 population health is so new, so outside of the
21 way in a traditional healthcare setting that
22 people think about healthcare that it's just

1 going to take some time to get over that
2 hurdle.

3 CO-CHAIR STANGE: Peggy, are you
4 able to say anything about the HHS Director's
5 Office interest in any ongoing supporting
6 initiative like this within NQF?

7 MS. HONORE: I can certainly
8 explore that if you could define it for me
9 better. Not now, but that could be explored.

10 DR. BURSTIN: And I think part of
11 the goal of today is to actually think about
12 what are the logical next steps, particularly
13 what can NQF help validate to this discussion.
14 So that may be helpful and we may get a good
15 sense of that through the course of this
16 discussion.

17 MS. HONORE: Okay.

18 MEMBER QASEEM: In your opinion,
19 primary care physicians do you think they're
20 more open, that there is a need for
21 essentially something like performance
22 measures in this arena? Because it's such a

1 new field, like you were saying, and do you
2 have any opinion on that? Where does the
3 primary care clinicians or where do they
4 stand? And I'm just asking because, I'm
5 sorry, I came in late. I don't know what's
6 your background, but you're involved with them
7 or not.

8 MS. HONORE: I really would not be
9 the appropriate person to make a blanket
10 statement about what primary care physicians
11 thinks or the way they behave. But I can say
12 that I can see interest in population health,
13 population health measurement. I can see it
14 growing and people beginning to understand the
15 value of it.

16 MEMBER QASEEM: So this interest,
17 where is it coming from? You're saying there
18 is interest, would you be able to tell there
19 is interest from who?

20 MS. HONORE: Well, I think any
21 time the government, you know initiates a
22 program and there's funding to support that

1 program that it provides an incentive for
2 people to become engaged and involved. And
3 some of the work that is going on at the
4 Innovation Center I think is going to promote
5 that over time. They have a very worthwhile
6 agenda and I think over time that it is
7 resonating.

8 CO-CHAIR JARRIS: Okay. Very
9 good. Thank you, Peggy.

10 One of the things you might
11 consider is an innovation grant to develop
12 measures because this takes support and there
13 is no support for it right now.

14 Amir, did you --

15 MEMBER QASEEM: So this question
16 is for the whole Committee. I'm just curious
17 do you guys have an answer of where this
18 primary care stands in terms of this?

19 CO-CHAIR STANGE: This is Kurt.

20 There's a special issue, a
21 combined issue of American Journal of
22 Preventive Medicine and American Journal of

1 Public Health coming out very soon that will
2 have a lot of papers to address that. One of
3 the papers is actually from a student of mine
4 who spent time interviewing various policy
5 people in Washington and found a tremendous
6 interest. And I think that anybody that is
7 able to step back, anybody in primary care is
8 able to step back from the hamster wheel of
9 day-to-day life and look at where things are
10 going, where the need is sees the strong need
11 for primary care to be much more integrated
12 with community and population and public
13 health approaches. And there are various
14 pilots that are going on around the country
15 that are exploring that.

16 And if you look at the historical
17 roots of primary care, if you look at the
18 definition of primary care it really includes
19 a population health focus practiced in the
20 context of family and community. So that is
21 the roots.

22 What has happened over the last

1 decade, in part actually because of the
2 plethora of disease specific quality measures
3 is that primary care has started to lose touch
4 with that root and has come to think of
5 quality as just doing a good job one disease
6 at a time where it really is the integrating
7 prioritizing personalizing functions of
8 primary care that are the source of the added
9 benefit that it is what provides meaning to
10 practitioners, provides value to patients and
11 value to society. So we're actually squeezing
12 this out. It is a core root thing.

13 So if you talk to people on the
14 front lines they're just barely trying to get
15 through the days right now. Anybody who gets
16 a chance to step back really sees the value of
17 this and it's what they would like in their
18 hearts and at the root to do. And it's what
19 I think anyone that looks at what our health
20 care system needs recognizes that we need a
21 better integration of primary care and public
22 and community health.

1 CO-CHAIR JARRIS: There are also
2 some thoughtful people in emergency medicine,
3 because in many ways ER absorbs the failures
4 of our society whereas violence, drugs, you
5 know uninsurance, unemployment. And again,
6 when they can step back there's some real
7 interesting thoughts among ER physicians about
8 what really would need to happen in the
9 community to prevent the failures that they
10 end up dealing with.

11 DR. BURSTIN: It'll also be
12 interesting to see as the emergence of the
13 medical home continues to move forward, maybe
14 we're waiting to see medical home, the CAHPS
15 for example. I don't know whether it will deal
16 with some of these whole health population
17 kinds of issues. It'll be interesting to see.

18 CO-CHAIR JARRIS: Matt?

19 MEMBER STIEFEL: I think another
20 important development to watch is the
21 Community Health Needs Assessments that are
22 driven by the Affordable Care Act, and that's

1 causing hospital systems and large health
2 systems in the country to really think a lot
3 more actively about these kinds of measures.

4 Paul Stange, are you any relation?

5 CO-CHAIR STANGE: No.

6 MEMBER STIEFEL: At CDC has been
7 working to try to develop a consistent and
8 coordinated framework for those Community
9 Health Need Assessments. And I think that's
10 a very significant opportunity.

11 CO-CHAIR JARRIS: There is
12 potential. Bobby and I have been working a
13 lot with American Hospital Association,
14 Catholic Hospital Association and others
15 trying to bring public health together with
16 that. And I'd say that there's a spectrum of
17 possibilities out there.

18 One end you have a strict
19 compliance with the 990 form, your accountant
20 will get you through this process. On the
21 other hand, there are some real innovators
22 looking at how hospitals and health systems

1 can improve the health of the community and
2 there's everything in between. And I think we
3 have to go through a -- if we're going to get
4 more people moving down that spectrum to a
5 meaningful engagement with the community and
6 what's going on, we have to go through a long
7 change process. And then there's also much
8 more comfort with the notion of engaging the
9 community and others in the assessment than
10 there is comfort with engaging the community
11 and others in the actual plan or activity to
12 improve the health. Because that creates a
13 level of accountability that many people don't
14 want to go to in the hospital community.

15 So, it's an interesting time of
16 trying to define what the full potential of
17 that is, which is incredible. But then it's
18 going to be a long change process to make it
19 happen.

20 Mike?

21 MEMBER STOTO: I want to agree
22 with both of those points. And I think it's

1 really important that we think through what
2 are the potential uses of these measures,
3 including the second part that you said.
4 Because I don't think that we -- for two
5 reasons.

6 One is that at the moment I don't
7 think the developers have incentives to do it
8 because they don't know about how they'll be
9 used. The other thing is I think that when we
10 think about the uses, that'll help us to think
11 through some of the criteria: What would make
12 a good measure and what should be included as
13 well.

14 The other thing I'd like to add is
15 that the accreditation standards also call for
16 using different words to saying two things:
17 Community Health Needs Assessments and the
18 Improvement Plans.

19 CO-CHAIR JARRIS: Yes, Bobby's can
20 talk about that for a long time. That's part
21 of what our interest here is requirements on
22 the public health community which are the same

1 requirements on the nonprofit hospitals and
2 why couldn't we put this process together. And
3 some get that and some -- I've seen some very
4 interesting letters about how this is an
5 attempt by public health to co-op the
6 hospital's resources to their own means. So,
7 yes, everywhere from this is -- you know sort
8 of war to what a good idea and we have a big
9 change process in front of us.

10 Why don't we take an opportunity
11 to -- Elisa, would you like to do some
12 introductions and then Peter and Neil, we'll
13 get to you next.

14 MS. MAINO-FIKE: Thank you.

15 Hi. I'm Lorraine Maino-Fike. As
16 you can see if you're here in the room, I am
17 your facilitator for the rest of the morning
18 in this conversation.

19 I've had some positive experience
20 with NQF and our organization has worked with
21 NQF in arranging and facilitating meetings
22 before. So I am somewhat familiar with the

1 organization and happy to be here.

2 My role is simply as facilitator
3 in this discussion trying to work you through
4 what are some of the causes of the low
5 response rate in this call for measures and
6 what you can do about that.

7 I am trying to make sure that we
8 also hear from the contributors that we have
9 remotely on the phone. Peter Briss from the
10 CDC and Neil Maizlish who is from the
11 California Department of Public Health. So
12 we'll make sure to get their participation
13 and feedback in the course of the morning
14 conversation.

15 CO-CHAIR JARRIS: Thanks,
16 Lorraine.

17 I would say certainly we want to
18 get to some of the -- you know, it's important
19 to look at the response rate and figure out
20 sort of the engineering of that process and
21 how it can be re-engineered. But I think we
22 also want to go way beyond that to look at

1 what is the purpose of this group, what is the
2 readiness of the field in general and how do
3 we facilitate development of this concept in
4 the field as well as how do we facilitate the
5 NQF process so those things can come together.
6 So although we want to get to some of the duct
7 tape and hard wiring, it's the bigger issue I
8 think we also need to get to.

9 MS. MAINO-FIKE: Well, I'm more
10 comfortable with standing next to the flip
11 chart. Part of what I think the benefit of
12 having a facilitator for a meeting like this
13 is that I can try to capture visually here on
14 the flip chart, you know low tech old
15 fashioned flip chart what some of the themes
16 of the conversation are.

17 Now, can the folks who are on the
18 phone hear me if I step away from this mic.

19 MS. MUNTHALI: If you're using the
20 microphone.

21 MS. MAINO-FIKE: Okay. Perfect.
22 All right.

1 So, as you said, thank you. We
2 want to look at the narrow focus of what are
3 some of the things that we think contributed
4 to or you all think contributed to the lower
5 than desired response rate. I think as we
6 said earlier, if you spend a little time
7 looking at or clarifying the uses and
8 objectives of the measures, then that might
9 drive your conversation around what those
10 measures might be or the criteria for them.
11 And then we can hear from our colleagues on
12 the phone regarding what might entice them or
13 what is in it for them in terms of responding
14 so we can get their perspective.

15 That conversation begs the larger
16 question, as you said, of then and we can
17 entertain this conversation as well: What
18 might be next? Might there be any role in
19 marrying measures with this population health?
20 And it seems as though now is the time to look
21 at what leverages among different
22 organizations might be out there for you all

1 to take advantage of.

2 So if I might first have you all
3 start with -- I know you did a little work
4 yesterday regarding what some of the
5 improvement opportunities were. What were
6 some of the themes that came out of that if
7 you want to capture them for the folks that
8 weren't a part of that?

9 For folks on the phone, we're
10 going to be pulling up some of the ideas that
11 were captured yesterday regarding what could
12 improve the response rate from support these
13 quality measures. However, we also want to
14 just bring you up to speed on what the initial
15 concerns or thoughts were there.

16 CO-CHAIR STANGE: The other
17 things, we're also looking at the larger
18 opportunity. I think many of us joined this
19 Committee with the idea that there is
20 something potentially transformative about
21 measuring the health and health determinants
22 of a population of a community. And that what

1 gets measured tends to be what gets paid
2 attention to, so there's something very
3 helpful in measuring that. So there's a large
4 opportunity and it is a frame shift for the
5 NQF that's been focused on clinical measures.

6 Healthcare is certainly a health
7 determinant, but it's also the big sucking
8 sound in our society that's pulling resources
9 away from some of the social and environmental
10 determinants of health. So there is that
11 larger frame for what we're doing and part of
12 the frame shift that we're looking at starting
13 with a process and a system that's really very
14 healthcare focused in trying to shift the
15 frame of reference to how we might focus on
16 measuring what's important to advance the
17 health of the population as opposed to improve
18 the quality of the healthcare of a population.
19 So that's a little bit bigger frame for the
20 question.

21 CO-CHAIR JARRIS: Mike?

22 MEMBER STOTO: Another idea from

1 yesterday I wanted to bring back is the one
2 that we've talked about -- about a population,
3 may be the population covered by an ACO or
4 some other healthcare unit. And population
5 measurements that are not just outcomes, but
6 measures -- okay. So we need measures that are
7 not just health outcomes, but measures that
8 really relate to processes and, for instance
9 that relate to those kinds of units.

10 So for instance, rather than
11 measuring immunization among the people who
12 happen to have come in for care during a given
13 year, you look at immunization coverage among
14 everybody who is a member of that population.

15 CO-CHAIR JARRIS: Or even the
16 outbreak of vaccine-preventable diseases like
17 pertussis in a community.

18 MEMBER STOTO: Sure.

19 CO-CHAIR JARRIS: Or measles that
20 we're seeing now.

21 MEMBER STOTO: But the point here
22 is that I think that there are process

1 measures within the covered populations as
2 opposed to geographical populations that those
3 measures are different if you think about the
4 population as opposed to the quality of care
5 provided to the people who happen to come in.

6 MS. MAINO-FIKE: Right. So if we
7 look at the measures that this group thinks
8 would be helpful moving forward, I hear what
9 you said. Both outcome based measures as well
10 as process based measures.

11 Are there other categories that we
12 want to make sure to capture in terms of what
13 would make good measures?

14 CO-CHAIR JARRIS: Go ahead, Bobby.

15 MEMBER PESTRONK: There is another
16 set of dimensions which I think Mike
17 referenced we talked about yesterday that have
18 to do with a geographic catchment area versus
19 an organizational catchment area. Having to
20 do with the political catchment area or some
21 other community-based catchment area. There's
22 another dimension that has to do with what

1 types of populations are we looking at,
2 specific racial and ethnic groups or people of
3 color or not. So in thinking about measuring
4 population health there are multiple
5 dimensions I think need to be considered.

6 MS. MAINO-FIKE: Right.

7 MEMBER PESTRONK: And we have to I
8 think clearly define for the purposes of NQF
9 what the communities of interests are because
10 I think we stumbled around that yesterday in
11 trying to figure out, okay, is this an
12 appropriate measure for this group to consider
13 or should that be considered in another group.

14 MS. MAINO-FIKE: Yes. So with this
15 notion of measures there are outcome type
16 measures, process type measures, different
17 populations that you want to make sure to
18 address and the measures for those different
19 categories might look different. So --

20 MEMBER PESTRONK: One other one,
21 if I can say. This group, and I mean it's
22 reasonable that we do, we see health as an

1 outcome and so we're looking at the social
2 determinants as processes or inputs to effect
3 that outcome. An interesting question to
4 explore is whether this group also ought to be
5 looking at the world as those who are in the
6 social determinant world look at health. For
7 them health is an input to their output, which
8 could be education or justice, or housing, or
9 transportation, or other social determinants.
10 And so an interesting way to push the envelop
11 potentially in NQF is to say why are we only
12 focused on measures that have to do with
13 health outcomes for populations? Could we
14 potentially be interested, could NQF
15 potentially be interested in the outputs that
16 others are looking for but that we see as
17 inputs, if that makes sense?

18 MS. MAINO-FIKE: Yes.

19 CO-CHAIR JARRIS: Matt, and then
20 Ron and then Sue.

21 MEMBER STIEFEL: Which then become
22 inputs to health, by the way. You know it's

1 a cycle.

2 We started our work with a bunch
3 of fun discussions about frameworks, and had
4 lots of frameworks. But all of those
5 frameworks converged and I think we've kind of
6 lost the connection with the background paper,
7 which I think laid out a very nice organizing
8 framework for our work, and it's probably
9 useful to recall it.

10 As Don was reminding us throughout
11 the day yesterday, they had this simple
12 construct of improvement activities,
13 determinants, and outcomes. And we spent
14 almost all of the day on improvement
15 activities, and it was just that that was what
16 we had in front of us. We got improvement
17 activities, by in large.

18 And that created lots of messiness
19 in that causal chain of evidence between
20 assessing BMI and weight and then the
21 downstream consequences of weight.

22 And so I think it's useful to sort

1 of bring that framework back up. And in most
2 of the frameworks there were these common
3 denominators of something about the social and
4 physical environment. You know, it's high
5 school graduation rates, crime, food deserts,
6 parks; that kind of thing. Behaviors:
7 Smoking, eating, drinking, exercise. And
8 those are ones that are actually easier to
9 draw the casual chain to outcomes.

10 Physiology, like BMI measures of
11 BMI are blood pressure, cholesterol, disease
12 and injury, which are pretty clear. Health
13 and functional status which, you know we're a
14 long way from with the measures that we have.

15 And then measures of death, which
16 are pretty fundamentally important population
17 health outcomes.

18 And then as Bobby talked about,
19 those then are can be means to broader
20 population goals of quality of life and other
21 factors which then become part of the social
22 and physical environmental determinants of

1 health.

2 I mean, so we've got a good
3 framework. We just didn't get in the call for
4 measures, measures in those categories. But
5 it seems like that's a useful framing to
6 continue to use.

7 MS. MAINO-FIKE: So in summarizing
8 what you're suggesting, the call for measures
9 addressed some improvement activities, and you
10 did get response on that. But there are some
11 other areas that could be addressed. You'd
12 like to get more data from your contributors
13 on. And that might suggest a second call for
14 measures with an updated survey, maybe
15 different kinds of questions or different ways
16 to frame the questions in a second survey. Is
17 that what you're saying?

18 MEMBER STIEFEL: And perhaps more
19 explicitly use these frameworks to call for
20 measures in those broad categories. Because
21 we ended up with health improvement activity
22 measures and not determinants or outcomes.

1 MS. MAINO-FIKE: Yes.

2 MEMBER STOTO: I think that Matt
3 is right, is that the background paper and our
4 discussions sort of laid it all out. But it's
5 not clear to me that the people who were
6 potentially proposing measures really were
7 aware of all that and had been thinking about
8 the kind of uses that we were just talking
9 about this morning. And I think there's been
10 a disconnect between our thinking about these
11 issues and we probably haven't clearly
12 communicated that.

13 CO-CHAIR JARRIS: It calls into
14 question how well did the call for measures
15 capture the concepts that we were trying to
16 get at.

17 Ron?

18 MEMBER BIALEK: I have a variety
19 of thoughts. And you know, Paul, you had
20 mentioned about fitting the square peg into
21 the round hole. And I think at times the hole
22 is round and at times it was triangular, at

1 times it was even square. I mean, so there
2 were some pieces there that were laid out and
3 understandable from the population
4 perspective, like the general criteria. But
5 then when you got to the work sheet, for
6 instance, the questions focused on something
7 different. And so now you had the square peg
8 in the square hole in terms of the criteria,
9 and now you have the rectangular hole. And so
10 I think it kept changing.

11 And if I may just talk for a
12 moment about my conversations with Legacy.
13 Because I thought that tobacco measures, at
14 least one, would be low-hanging fruit. I
15 mean, there's a lot of research, a lot of
16 evidence on these types of measures.

17 And so I think we have two things
18 here. One is where there are existing
19 measures, the low-hanging fruit, how do we get
20 those brought here? And then the second is
21 for measure developers how do we encourage
22 measure development in a way that can really

1 fit with this?

2 So let's go back to the measures
3 that already exist. What the Legacy folks
4 first had in my initial conversation is why.
5 Why would we want to submit something to NQF?
6 What is NQF? What's the relevance to what it
7 is we do? And that was a considerable
8 discussion back and forth, and I think the NQF
9 staff helped to clarify that on a call. But
10 that took a bit of time to understand, and I'm
11 still not sure it's fully understood what the
12 benefit is to an organization like NQF for
13 having a tobacco -- I'm sorry. By Legacy to
14 have a tobacco measure approved by NQF.

15 Second was the work load and time
16 frame, I know that's been brought up. That
17 they just didn't have enough time to do it
18 well because from the announcement to
19 contacting them, to discussions about the
20 benefits, to what the measures could be that
21 gave them, let's say a week or less from the
22 time they finally decided which measure and

1 then submitting.

2 There are lack of examples, good
3 examples of -- you know often this isn't well
4 understood, no matter how well we describe it
5 in the background paper that was developed and
6 other papers, seeing some examples even if
7 they are fictional examples of what this might
8 be or what might fit, would help.

9 Suggestions from the Steering
10 Committee. So, you know we talked with Legacy
11 about prevalence, about taxation, about indoor
12 air. Well, is there a preference from the
13 Steering Committee about which types of
14 measures might resonant the best, might be the
15 ones to bring forward initially?

16 That is -- let's see. Yes. I'll
17 just come back again to the work sheet where
18 it didn't necessarily provide the guidance
19 that was desirable for that.

20 MS. MAINO-FIKE: This seems like
21 the perfect entree to actually touch base with
22 our developers, contributors that are on the

1 phone and ask them for their feedback as to
2 what were the reasons that they were not able
3 to participate. We know some of that was
4 resource. But also what benefits could they
5 see for themselves, kind of a what's in it for
6 them around what would they like to see in
7 measures? Do they see some leverage in
8 submitting information to an organization such
9 as NQF?

10 So, with that I'm going to ask --

11 CO-CHAIR JARRIS: Can I just --
12 Sue, did you see something? Did you have your
13 card up?

14 MEMBER PICKENS: Yes.

15 CO-CHAIR JARRIS: Okay. All right.

16 MEMBER PICKENS: Actually, they
17 covered it.

18 CO-CHAIR JARRIS: All right.

19 MEMBER PICKENS: How far upstream
20 did we want to go because we did all that work
21 on the model.

22 CO-CHAIR JARRIS: All right. Can

1 I say something? One thing I want to
2 reenforce you said, Ron, because in a sense
3 you brought up the NCQA branding issue -- NQF
4 branding issue. And, you now, NQF would have
5 to rebrand to make itself of value to the
6 population health, public health community.
7 That assumption was there that the public
8 health community would understand that. And
9 I think what we learned is they didn't, you
10 know. Xerox makes copies, right? And Xerox
11 also runs most of the E-ZPass toll booths in
12 this country. You never would have thought
13 about that.

14 So, I don't know that NQF
15 appreciated the rebranding process here.

16 And then if I could add one more
17 thing that came up, I think, yesterday was
18 that you know a lot of these measures were
19 one-on-one clinical measures which is useful,
20 but that's largely -- I mean, I guess that's
21 part of tier 1 in this group. But then you
22 have the issue of, okay, so you measure does

1 the doctor give the right vaccine measure of
2 BMI. But it's a separate measure to say, okay,
3 then what is the vaccination rate among this
4 whole clinical population served by this
5 health group? We have less those types of
6 measures.

7 And then you take another step:
8 What is the vaccination rate in the community
9 served by that hospital outside of their
10 direct patients? We didn't get anything like
11 that.

12 You could take a step further more
13 outcome to say, okay. what is the rate of
14 vaccine preventable disease outbreak in this
15 community, which is still another step
16 further.

17 And then what we didn't get, which
18 I think we talked about in the NPP process in
19 here, is that's still a disease or deficit
20 model. We never got to anything that measures
21 the well-being of the population and the
22 community.

1 And so there's a long way to go
2 down that spectrum and we're still very much
3 on the first step about doctor/patient
4 interaction. We haven't even gone to a
5 population approach for that clinical study.
6 We did one exception of that HIV measure I
7 think, which is a very good first measure for
8 us to approve.

9 Mike?

10 MEMBER STOTO: You know, I think
11 one of the things is that NQF has been around
12 for a while and serves a very important
13 purpose, but I don't think we've been very
14 explicit about what that purpose is or why
15 people in the clinical world see value in NQF.
16 And maybe if we could sort of lay that out and
17 then think how does that translate.

18 I imagine it's because you need to
19 have NQF endorsed measures for certain
20 purposes. For accreditation or pay-for-
21 performance, or something like that. There's
22 some value in having NQF endorsement, but I'm

1 not sure that the public health world
2 understands what those are.

3 CO-CHAIR JARRIS: You should
4 understand what the value is because as
5 occurred to me yesterday, I mean who does
6 submit a measure to NQF and who is it a value
7 to? NCQA would be because then they had some
8 credibility to their measure when they go to
9 health plans. I think CMS the same thing;
10 they're going out to hold ACOs accountability
11 just as a measure of credibility.

12 Do doctors and clinicians actually
13 care? Do they even know? And then why would
14 the public health people care when NCQA is
15 core to their business to get this
16 endorsement?

17 MEMBER STOTO: Right.

18 CO-CHAIR JARRIS: And CMS is core
19 to their business. In what way is this
20 accreditation core or meaningful, or
21 beneficial to someone in the population health
22 world, or are they being asked to do something

1 for someone else's benefit?

2 MEMBER STOTO: So if IRS said you
3 need to have NQF endorsed measures for your
4 Community Health Needs Assessment, well then
5 it would pay attention to it?

6 CO-CHAIR JARRIS: Yes.

7 DR. BURSTIN: It's very analogous.
8 If hospitals need to have endorsed measures --
9 you know if all these different pay-for-
10 performance programs, purchasing, public
11 reporting programs need NQF measures, then
12 those developers are going to make a march to
13 NQF to bring those forward because they want
14 those done.

15 The other thing is though on the
16 side of the clinicians and the providers, and
17 I'd be curious some of the folks in the room,
18 the biggest thing we hear is that in some ways
19 it removes the noise in the debate. If an NQF
20 endorsed measure comes forward to a hospital
21 and says let's use this one, they sort of feel
22 like they could dispense with the evidence and

1 a lot of the stuff has already been taken care
2 of as part of the process, and they just kind
3 of eliminate a lot of the angst and just move
4 forward with it and focus on measurement and
5 improvement.

6 So, I mean but again I think the
7 issue -- I think you're absolutely right. We
8 haven't really dealt with this. What's the
9 benefit to the public? And again, I think
10 this whole issue of all the terms we've used
11 interchangeably through the course of this
12 project are still very confusing, at least to
13 me at least in terms of what is public health,
14 population health, community health and then
15 you know how tethered should it be ultimately
16 back to the health care system? I mean
17 there's some very different models in terms of
18 looking at rates of community vaccination, I
19 think is still pretty close because it's still
20 directly relevant to a health care system or
21 an ACO to understand what's out there. There
22 are some things that go further and further

1 layers out without that tether back, and I
2 think that's where we really need to think
3 about how relevant those are and whether the
4 public health community sees any value in
5 bringing those forward to NQF.

6 MS. MAINO-FIKE: Right. And we
7 can brainstorm what some of those values might
8 be.

9 I'm sorry, did I interrupt you?

10 MEMBER PICKENS: I'm sorry. I'm
11 working very hard with our region on a new
12 1115 waiver for Texas. The entire category 4
13 is all NQF measures, mostly around the
14 potentially avoidable and admissions and
15 readmissions. But the immunizations are there
16 and some utilization measures are there. But
17 they're all of value to the state of Texas
18 because that's for the entire state.

19 MEMBER STIEFEL: I think we should
20 think of this marketing strategy not just to
21 the public health community, but I think it's
22 important in marketing to health care delivery

1 systems to expand their thinking to think of
2 upstream determinants of health. And there is
3 a closer relationship with NQF already built
4 into the health care delivery system, and I
5 think that that's an important driver of this
6 change. I think we're trying to -- we're at
7 this boundary between public health and health
8 care delivery or clinical health.

9 And, you know a very modest step
10 would be if we have just moved upstream a step
11 to behaviors. If we had smoking, eating,
12 drinking and exercise as measures for health
13 care delivery systems, that would be an
14 enormous step and move us closer to the
15 upstream determinants.

16 CO-CHAIR JARRIS: Matt, it raises
17 the question, you know NQF wants to enter this
18 field. Have they made that decision? You now,
19 before Starbucks would open a new product line
20 their Board of Directors would really weigh do
21 they want to go down that product line. And
22 how seriously has the Board considered that or

1 is this just the work of one temporary work
2 group or has this fundamentally been endorsed
3 and understood by the Board?

4 And to the extent we're struggling
5 with it, I would almost guarantee you the
6 Board can't understand any better than we do.

7 DR. BURSTIN: I think depending on
8 the rings of how far outside of health care
9 you're going, you're going to get less and
10 less agreement. I think, you know the
11 measures we talk about that are clearly more
12 at a population level but somehow still have
13 a connection back to sort of health care
14 system measures, you know that Matt and Sue
15 just talked about, I don't think there's any
16 debate at all. Everybody gets the ACO,
17 everybody understands the movement towards
18 that. NPP's been very clear about that.

19 I think what is less and less
20 clear are things where there may be measures
21 for which the accountability, shared though it
22 may be, to the health care system is more

1 tenuous. And so, for example, some of the
2 measures we talked about: Taxation rates for
3 smoking. I think that may be a place you'd
4 start to see some discomfort on the part of
5 some typical sort of leaders within NQF,
6 whereas I think understanding your community
7 smoking rates, no brainier. It's incredibly
8 useful, it's useful information to you as a
9 health care system and a provider to have that
10 information to move and make improvement. And
11 I think it's when they feel slightly further
12 and further out of those circles that I think
13 you get into more debate.

14 MS. MAINO-FIKE: And again, for
15 your own information I want to give our remote
16 folks who are the contributor population, if
17 you will, the opportunity to share their
18 thoughts on what would they see as value to
19 participating in a measurement survey such as
20 this, what are the challenges that they face.

21 With that, I will just ask our CDC
22 representative, Peter.

1 DR. BRISS: Good morning. I'm
2 Peter Briss. Can you hear me?

3 MS. MAINO-FIKE: Yes, Peter.

4 MEMBER QASEEM: Just one second. I
5 want to call up something that Paul started
6 saying, because I think it's extremely
7 important.

8 In my mind I think that's exactly
9 the issue with population health measures.
10 You're applying the same concept that we've
11 been using for the disease-based measures now
12 on a population level.

13 I was just thinking that the
14 movement to have guidelines, for example,
15 comorbid conditions because we have been
16 issuing these guidelines just for COPD or for
17 diabetes, you know the thing about it. But
18 you're treating this patient who comes with
19 multiple conditions, right?

20 The goal of population health
21 measures is to improve the health of the whole
22 population. But now we're taking these

1 individual measures that are based on these
2 guidelines, disease focused guidelines which
3 it may improve how to measure for that
4 particular -- if it's applied or however it
5 gets applied, but it is not going to increase
6 the overall health of the population.

7 And I think NQF is in a very good
8 position. This is a new field we are starting
9 on. And I think we need to maybe first take a
10 step back and think about maybe NQF maybe may
11 not be the forum, that what do we need to do
12 to improve the quality of the population?
13 What sort of measures do we really need?

14 I think we're really isolating. I
15 mean yesterday if you think about it what
16 measures did we review? We're looking at
17 three or four disease conditions, right? I
18 feel that there is a huge disconnect, that's
19 not going to lead to -- because we're
20 separating so many other factors that go with
21 the population. I think in terms of what's
22 going on with the population. And I think we

1 need to think of it all as a collective format
2 and then do a lot of measures.

3 And then there is some work that
4 has been done in this arena. Again, I am not
5 the biggest expert in it. But I know that some
6 folks have written about this specific issue,
7 as well as Paul. So I just want to bring this
8 up that I think what you raise is extremely
9 important and maybe we need to really look
10 into that.

11 MS. MAINO-FIKE: Thank you, Amir.

12 The notion here of casting your
13 net wide, looking at some broader upstream
14 kinds of determinants for what would impact or
15 how to measure population health.

16 And again, I want to get back to
17 our remote partners and give them an
18 opportunity to contribute.

19 DR. BRISS: Hi. This is Peter
20 Briss. Can you hear me?

21 MS. MAINO-FIKE: Yes.

22 DR. BRISS: Okay. So I'm Peter

1 Briss. I'm from CDC.

2 I have spoken with many of the
3 people at CDC who are sort of working in this
4 general area, so this is to some extent a
5 synthesized view. I don't pretend that this
6 completely reflects all 15,000 people at CDC.

7 So first we agree with Kurt and
8 others that there's an enormous amount of
9 interest now inside and outside of government
10 at sort of working at the clinical and
11 community interface and in better linking what
12 health care systems and community health
13 systems are doing. So there's an enormous
14 amount of interest and support for your work.
15 And on the private side things like the
16 National Priorities Partnership Population
17 Health Working Group, which I on behalf of CDC
18 have been helping to Co-Chair, for example.
19 And there are scads of governmental examples,
20 community health needs, work that Paul is
21 doing that you've given already. The CMMI's
22 brand new health care innovation challenge is

1 to some extent very population health focused.
2 I'm really excited about it.

3 HHS' Million Hearts Initiative is
4 a very nice example of pulling together
5 clinical and community work.

6 So, there's an enormous amount of
7 support and enthusiasm for the kind of work
8 you're trying to move forward.

9 The second point would be that we
10 think that there's no strong technical reason
11 that the sorts of evaluation criteria that NQF
12 uses about impact and validity and usability
13 and feasibility couldn't be applied to
14 population health kinds of measures and
15 topics, perhaps sometimes with some tweaking.

16 A third major point, and this is
17 probably the most important point, is I think
18 it was Mike Stoto who said the collective "we"
19 on the Committee and in public health more
20 generally haven't made a convincing case to
21 answer the why are we doing this, how will
22 these measures be used, what's the value added

1 of NQF endorsement in this context? We think
2 that the fairly thin response that you've
3 gotten primarily reflect our lack of making a
4 convincing case about how these measures will
5 be used. And probably without us making a
6 much crisper case about what are the proposed
7 uses, it seems unlikely to use that we're
8 going to make major steps forward in this
9 area.

10 And perhaps to echo what Helen was
11 just saying, the case gets harder to make for
12 the farther you get away from clinical care.
13 So it's not obvious -- at this point I'm going
14 to speak for Peter and I'm not speaking for
15 CDC or the wider world. But it's never been
16 apparent to me that people who are working on
17 social and environmental drivers of health are
18 necessarily looking to NQF for endorsement of
19 measures.

20 And I guess the final thing I
21 would raise in this category of work is I
22 think we need to think really carefully about

1 whether building in NQF endorsement sort of
2 into measurement and payment kind of systems
3 might have unwanted negative effect. It would
4 be a shame I would think, for example, for a
5 Community Health Needs Assessment if we built
6 requirements for NQF endorsement that had the
7 unintended effect that I think is negative of
8 pushing us to only looking at sort of clinical
9 measures, of which there are now 700 plus and
10 pushing us away from using sort of more
11 geographic population health measures which
12 are likely to be much more under represented.

13 And then finally given everybody
14 on the -- Helen and others who are very
15 involved in the NQF process knows that many
16 measure developers feel that the NQF process
17 can be arduous. And given a lot of
18 uncertainty about how the measures are likely
19 to be used, it's very hard for people to make
20 the return on investment case at the moment in
21 their home organizations that the upside of
22 NQF endorsement today is worth the significant

1 investment in getting measures endorsed.

2 CO-CHAIR JARRIS: Peter, is there
3 another process that exists and if it does, is
4 it more relevant than NQF, for example CDC
5 folks creating population health measures?
6 What is the process, for example, of
7 standardizing across -- if there is one,
8 across surveys so that the same questions
9 asked on the YRBS as the BRFSS and other CDC
10 related surveys out there? Or, does each
11 program come up with their own measures and
12 validate their own measures independently
13 without any process for developing common
14 measures across programmatic areas?

15 DR. BRISS: Yes. I can start on
16 this topic. There are likely to be several
17 people around the real and virtual table up
18 there that know as much or more about this
19 than I do.

20 So I would say that public health
21 has not been perfect about sort of aligning
22 measures and making them coherent across

1 surveys and programs. And to be fair to public
2 health, Helen and others up there know that
3 the clinical world hasn't been perfect about
4 that either. All of us are trying to work on
5 that.

6 There's a fair amount of inside
7 intergovernmental conversation about those
8 kinds of points. And within agencies, across
9 agencies and with cross governmental groups
10 like OMB, but it's not perfect as it stands.

11 I don't think that there's a
12 current external kind of Good Housekeeping
13 Seal of Approval that would do what you're
14 talking about, Paul. And if there were such
15 a group, we'd probably have to be -- that
16 would certainly have both costs and benefits
17 and we'd be having a conversation I suspect
18 much like this one about needing to very
19 cleanly make the case that the upside exceeds
20 the potential downsides.

21 DR. BURSTIN: Peter, just a
22 follow-up question. This is Helen.

1 This is very helpful. Just one
2 thought as you talked about the surveys,
3 standardizing the surveys for example, I think
4 one place where there would be huge benefits
5 would be if the measures used by the health
6 care systems, the clinicians and others in
7 fact standardized the approach to asking about
8 some of those health behaviors that you
9 already do in all your surveys in the same
10 ways? You could in fact say: "My health
11 system is falling down within our community,
12 within our state in a way that we can't do now
13 because is nothing is sort of harmonized in a
14 way that makes any sense."

15 DR. BRISS: I agree with that,
16 Helen. And in addition to that that also sort
17 of links a little bit to the last point that
18 you were making about a starting point where
19 the inner most concentric circle were NQF
20 endorsements and help from NQF in sort of
21 standardizing or aligning, or making as
22 consistent as possible some of the survey work

1 and some of the quality measures, the health
2 care quality measurement work would allow all
3 of us to do more sort of rolling up and down
4 measurement efforts from the individual
5 provider level to the health care system
6 level, to the community level to something
7 like the state or national level. And that
8 would be a really important -- that may not be
9 all we want to do in population health, but
10 that would be a really important practical
11 step forward, I think.

12 CO-CHAIR JARRIS: Peter, Howard
13 Koh announced around the time that Healthy
14 People 2020 measures came out that HHS had
15 developed a common set of measures for surveys
16 on health equity. And I don't know if you or
17 Peggy know anymore about that, but that's the
18 first I've heard about that being done across
19 HHS. It's a very important area, and it's an
20 area that we got nothing on. So, are you
21 familiar with that, or Peggy?

22 DR. BRISS: I think that's closer

1 to Peggy's wheelhouse than it's likely to be
2 to mine.

3 MS. MAINO-FIKE: We're just making
4 sure you can hear Peggy. We're giving her a
5 microphone.

6 MS. HONORE: I think there's
7 probably two reports that it could possibly
8 be. And, Paul, you're familiar with the NPA.
9 I don't think -- they may touch some on that,
10 but also the HHS wide health equity plan, and
11 I may not have the title of the report, that
12 may not be the exact title of the report, but
13 perhaps that's what he was referring to.

14 CO-CHAIR JARRIS: I recall it
15 being specifically measures and how HHS was
16 going to measure across different surveys, or
17 maybe "measures" is the wrong word. How
18 they're going to -- there's common language to
19 be used in the surveys around health equity.

20 DR. BURSTIN: It's not just the
21 OMB category, it's to categorize race
22 ethnicity --

1 MS. HONORE: Maybe that's what it
2 is. In the Affordable Care Act, and I forget
3 which exact section it was, but there was a
4 mandate that work be done to explicitly define
5 certain categories race and ethnicity but also
6 that there be reporting requirements that
7 people report under those specific categories.
8 So that's probably what he was talking about.
9 And that's being done in stages, like they've
10 done stage 1 and I think that may include some
11 specific sort of surveys that are currently
12 being done. And then they're going to roll it
13 out and develop those definitions for other
14 types of data collection efforts as well.

15 I can get you some information on
16 that.

17 MS. MAINO-FIKE: Just in a summary
18 capacity here, what I've begun to do,
19 particularly for those folks on the phone, is
20 to organize or structure the comments that
21 people are making in terms of future steps of
22 needs, things that could be looked at and

1 might require future work, and then another
2 category is measures; the kinds of things we
3 want to or you want to include in measures.
4 Things like outcome-based, process-based.

5 So the kinds of things I put under
6 future steps or needs are not necessarily that
7 you all as a group or NQF has agreed to pursue
8 them, but rather items that have come up as a
9 result of this discussion that could be
10 pursued should this group and NQF choose to do
11 so. So things like standardization that we've
12 been talking about most recently across
13 organizations. Standardization of definition.
14 Standardization of measures. And there are a
15 lot of work or organizations to leverage off
16 of, like HHS, like even with IRS if they're
17 through ACA developing common survey
18 definitions.

19 Things like marketing or making
20 the case for how these measures could be used.

21 Things like over here on this side
22 why -- the benefits to developers for

1 responding to NQF. So kind of a
2 branding/marketing opportunity for NQF as a
3 whole if they choose to do so in terms of
4 taking a role in moving this conversation
5 forward.

6 So as you're talking, I'm kind of
7 looking at trying to capture the ideas that
8 you have so that we don't lose them in terms
9 of potential action items to move forward.

10 DR. BURSTIN: Just one comment.
11 I'm not so sure it's a branding exercise for
12 NQF. I think it's less about NQF. I think
13 it's more about what's the value case for
14 bringing these measures to NQF? What are the
15 benefits to the developers? What are the
16 benefits to the broader system?

17 MS. MAINO-FIKE: Yes.

18 DR. BURSTIN: And I think that's
19 the piece that I'd like us to noodle a bit
20 more.

21 MS. MAINO-FIKE: Yes. And I do
22 have that written down, too. So I apologize

1 for saying specifically branding, although
2 that was one small piece of the pie.

3 DR. BURSTIN: We can say we're
4 perfectly interested in it. We say we embrace
5 population health. But if the community still
6 doesn't see a value case for doing it, it
7 doesn't really matter.

8 CO-CHAIR JARRIS: But I would
9 explicitly use branding because the question
10 for me is, and I just may be ignorant, is does
11 the NQF Board really understand this area and
12 are they really willing to address it in a
13 meaningful way even if that means changing the
14 way NQF does business and changing the
15 outreach that they do, which would frankly
16 mean everything from changing the makeup to
17 their Board, to changing the way business is
18 done, perhaps even changing the organization.
19 Because currently it's structured for clinical
20 measures, it's not structured for population
21 health measures.

22 So, is there truly commitment to

1 this? Because if there isn't, I just think
2 it's just not going to happen.

3 DR. BURSTIN: I think there is.
4 But I think a lot of it is people are waiting
5 to see what came in and trying to understand
6 where are the boundaries is what I think we
7 would have hit debate on as opposed to I think
8 some of the kind of things. I mean, I don't
9 think anybody would blink about the HIV
10 measure yesterday. No one would blink on the
11 Board or anywhere. That was a great measure.
12 It's incredibly useful at lots of different
13 levels, including the health care system.

14 I think when you start to get out
15 to measures that have no tether back or not as
16 easy a tether back, I think that's where
17 you'll hit a snag.

18 DR. BRISS: And this is Peter.
19 Can I comment on that as well?

20 MS. MAINO-FIKE: Yes.

21 DR. BRISS: And so, Paul, this is
22 Peter. I represent CDC on the Board and I

1 thought I'd comment on that as well.

2 I think that my guess is that
3 especially as we get further away from the
4 health care system that we're going to have
5 the same case making issues for the Board that
6 we sort of seem to have with the public health
7 community. I think that having the Board
8 discussion first might actually be a cart
9 before the horse thing. I think that if we
10 can make a crisp case for what the value case
11 is, then we can sell it. If we can't make a
12 crisp case, then we won't be able to sell it
13 either to the Board or to the community.

14 MS. MAINO-FIKE: Good point.

15 Thank you.

16 Yes, I'm just wondering about our
17 other remote participants. Neil, like to make
18 sure you get an opportunity to share your
19 thoughts.

20 DR. MAIZLISH: Sure. Can you hear
21 me okay?

22 MS. MAINO-FIKE: Yes.

1 DR. MAIZLISH: Okay. Great.

2 First of all, I want to thank you
3 for inviting me to participate. It's been a
4 pretty interesting conversation so far.

5 I suspect unlike many of my
6 colleagues in public health I actually know
7 about NQF. I've known about it for over ten
8 years, partly because of my background. I
9 helped the Consortium of Community Clinics in
10 the Bay Area establish a quantitative clinical
11 quality improvement program. So I actually
12 know about NQF from that study because I was
13 looking at non-HEDIS measures for some of the
14 activities that our clinic system implemented.

15 I'd like to just address the
16 social determinants of health, part of what
17 you are interested in. I mean, that's where
18 my work now in the California Department of
19 Public Health resides. And I just want to
20 say, I mean I was listening before talking
21 about the readiness of various communities to
22 embrace especially determinative health types

1 of indicators upstream indicators. And it's
2 just to say that many health departments or
3 local health departments in California, this
4 paradigm has shifted, discussion isn't so much
5 about whether there's evidence for it.
6 There's a framework that are now being adopted
7 that explicitly look at very upstream
8 conditions and presents an entire continuum
9 from institutional power and structural
10 racism, and how those things, the economic
11 activities influence basic living conditions
12 of populations and how those things influence
13 individual behaviors and behavioral risk
14 factors, and then onward towards actualization
15 of morbidity and mortality. And people are
16 very clear about where the points of
17 intervention are as far as the primary care,
18 the practitioners, health care systems, public
19 health departments and then going further
20 upstream to the organizations and the
21 institutions in society that has their hand on
22 the throttle more so than the health folks.

1 Also in California there's the
2 sustainability movement which is driven by
3 climate change concerns and population growth
4 concerns. They've recognized that health is
5 a partner. Part of it is that public health
6 pushing its way to the table and when it's not
7 explicitly asked, but we see the connections
8 to these upstream determinants. So in that
9 sense the institutional climate in California,
10 at least, is definitely receptive. And it
11 also extends to the party who might be tied to
12 interventions outside of public health, like
13 municipal governments, regional planning
14 agencies, state agencies. And they see that
15 they need help as a partner in this process
16 and the credibility that health brings to the
17 discussions about these social determinants
18 that you can't under estimate how important
19 that really is when the public health
20 department joins with a regional planning
21 agency to say that, yes, we need to increase
22 biking and walking as part of our

1 transportation plan because it's going to have
2 a big impact on population health or physical
3 activity. That really does resonate.

4 And I just want to emphasize that
5 while there is a debate in the room about the
6 readiness of the various parties, some of it
7 has already happened. And I guess I'll use a
8 metaphor that, you know addressing why you may
9 have had a low response rate.

10 You know in a sense it feels like
11 you've invited people to a party that started
12 over 25 years ago for some of the
13 participants. And I'm talking about
14 communities like Jacksonville, Florida or
15 Santa Cruz in California where they've had
16 community indicator projects looking at many
17 of the things that people have suggested as
18 social determinants of health in the arena of
19 housing, education, economic development,
20 social cohesion. Many have had projects going
21 on for over 25 years in some cases, and some
22 of them are incredibly elaborate projects

1 where they engage private social survey
2 companies to interview thousands of residents
3 to determine everything from how city services
4 and municipal services are provided to whether
5 you think the board of education is doing a
6 good job. So you have a sort of kind of
7 granularity there, but you also have total
8 chaos in the sense that there are hundreds and
9 hundreds of these kinds of projects already
10 going on. You know, some of them like the
11 Jacksonville project, the Boston indicators
12 project are just examples of things that have
13 a real longevity. And I doubt people would
14 just keep on doing it and invest the resources
15 they invest. I mean, it's part of the
16 continuous quality improvement movement that
17 they see that they're tied into.

18 I think our interest in California
19 in part is that we know we're going to go
20 ahead with the indicators on the social
21 determinants of health, but how do you rein in
22 this chaos or this great need for

1 standardization that we see? And this is
2 where there's a logical connection to NQF
3 because we want to make sure that whatever
4 we're doing is harmonized with what other
5 organizations are doing and that they see
6 value in that.

7 You know, why at this time we
8 weren't able to submit a rubric of indicators
9 is partly due to timing. We are lucky to have
10 a small research and development grant from
11 the Strategic Growth Council, which is an
12 entity that represents the large state
13 agencies working on green house gas mitigation
14 and sustainability in California. And they
15 have a Health Policy Task Force composed of 18
16 state agencies that basically created a series
17 of aspirational goals to which -- I mean, this
18 I think has been circulated among the
19 Committee, your Committee. But it's a series
20 of aspirational goals that had a tremendous
21 amount of community input as well. So it's not
22 just, you know high level directors or deputy

1 directors of large state agencies, but this is
2 taken around the state and a number of
3 communities for us to get input from community
4 members and local health departments, from
5 community-based organizations, from
6 environmental justice groups. So it's a
7 pretty wide ranging group of folks who had
8 input. So this is a numbered approach to
9 getting -- you're setting up aspirational
10 goals, deconstructing them into indicators and
11 then trying to address that from that
12 standpoint. So the process is really top down
13 and bottom up in our situation.

14 Now some of the challenges, as I
15 mentioned, we have this research and
16 development grant from the Strategic Growth
17 Council to work on its task force aspirational
18 goals, to turn them into indicators. And we
19 just started the project, so it's just a
20 matter of timing. If the call had come out a
21 year from now, we'd probably be in a much
22 better position to actually provide much of

1 the information that would support the
2 criteria.

3 We don't particularly have an
4 issue with the rigor, the issues around
5 validity and precision that generally
6 indicator development. I think we will have
7 a challenge with the evidence-base. It won't
8 be based on clinical trials as many of the
9 clinical measures ideally are. So I think
10 there's going to be a certain -- I don't know
11 if it will be uneasiness maybe in the clinical
12 world to see the level of what's considered
13 evidence and validity might be visited. That
14 it may be a series of is it syllogisms that
15 this is related to that, which is related to
16 B and C and D and that we see a casual chain
17 here, but we can't through either hierarchical
18 modeling or other things demonstrate what the
19 population attributable risk is to any
20 individual factor that may be considered way
21 upstream. But we will try to get that
22 evidence and try to create some kind of

1 framework for evaluating that.

2 So we're not put off by that
3 piece, which I think some organizations may
4 not have the resources to do that.

5 One more challenge is the
6 geographic downscaling. That's one of our
7 missions. And I know that may be perhaps at
8 odds with some of the materials in the
9 background paper where a premium is going to
10 be put on measures that can have a national
11 scope. And that relies often on data that are
12 survey-based. And when you get to sub-county
13 levels the stability of those measures
14 basically breaks down.

15 I know there's been a lot of work
16 in modeling of some of those things. But I can
17 tell you from working directly with lots of
18 epidemiologists and local health departments
19 there's a certain queasiness about model data
20 for the purpose of monitoring performance.
21 They're less queasy about it being used in
22 predictive models for things that might be

1 happening 20 or 30 years from now. So, this
2 is a real challenge, which means that in some
3 cases local data sets will have more value or
4 get a higher priority.

5 The other challenges that I think
6 we have is just the administrative
7 arrangements with some of the data owners.
8 Where it's public domain data, there's not
9 going to be a problem. But one of the values
10 that we as a state agency California offers
11 that we can leverage our position in the state
12 to work with other state agencies that might
13 be data owners. Actually, very little of the
14 data that's on our preliminary draft list is
15 data that the California Department of Public
16 Health owns. There's a few items that are
17 behavioral risk factors, like smoking
18 prevalence and production of fresh fruits and
19 vegetables, and levels of physical activity
20 through our California Health Interview
21 Survey. But many of the data are owned by
22 other agencies, whether it's the Department of

1 Education or the Department of Agriculture, or
2 Economic Development and we will need to
3 broker administrative arrangements that those
4 agencies, and they have confidentiality
5 arrangements with some of the participants in
6 their surveys that may prevent them from
7 sharing individual identifiers, arranging
8 aggregations through third parties or some
9 arrangement is going to be a challenge for us
10 to get some that data.

11 These are some of the --

12 MS. MAINO-FIKE: What about the
13 confidentiality piece? Nobody's brought that
14 up, but that is a good point regarding what
15 might make people hesitant in responding.

16 DR. MAIZLISH: Yes.

17 So maybe I'll just leave it at
18 that, I mean as far as addressing some of the
19 specific reasons why we didn't move further
20 than we have on submitting something. But we
21 did see the value of standardization and I'm
22 pretty sure that organizations like NQF will

1 have in seeing that these measures are adopted
2 and it feeds into a accreditation processes
3 for the health departments, local health
4 departments. So there's some business reasons
5 on our end that we see the value to having a
6 standard rubric of indicators of the social
7 determinants of health that will be very
8 useful.

9 There are many business processes
10 within local health departments, many of them
11 do health status reports periodically that go
12 beyond the vital statistics of, you know,
13 birth and death data. And these kinds of
14 indicators and their underlying data will
15 advance their ability to do more sophisticated
16 health status reports that integrate both the
17 health side and the social determinant side.
18 So what is now an exception for a few large
19 health departments for Alameda County, Los
20 Angeles County and a few others will be
21 routine activity. And so that's hopefully
22 where this will go. And so I'll just leave it

1 at that just so that other people can
2 participate.

3 CO-CHAIR JARRIS: You know, that
4 was very helpful and I think your point that
5 there's a lot of, I guess noise out there is
6 partly departmental in the field, but it also
7 as you say raises the issue that it would be
8 very helpful to create some way of decreasing
9 that noise or standardizing some of these
10 measures.

11 You mentioned organizations like
12 the NQF. Are there others that are
13 potentially in this space that could --

14 DR. MAIZLISH: Oh, my gosh. You
15 bet. I've been in touch with some of them.

16 There is ICLEI, which is an
17 organization of municipalities that is
18 creating a, it's called STAR, S-T-A-R, and it
19 -- is a rating system. And they are including
20 indicators -- indicators of social
21 determinants of health for municipal
22 governments. And this is in part part of the

1 stateability movement around the country. So
2 I've been in touch with them.

3 MS. MAINO-FIKE: Excuse me. What
4 was the name of that organization again?

5 DR. MAIZLISH: It's ICLEI, I-C-L-
6 E-I. And it's -- I can't remember if it's the
7 international league of communities something.
8 It started out as sort of an environmental
9 based organization but they've branched out
10 quite a bit. It's a membership organization
11 that has several hundred communities around
12 the United States that are participating.
13 They have a data group, and I participated.
14 Actually, Vickie Boothe at CDC was one of the
15 representatives from CDC. I don't know if Paul
16 knows -- CDC, it's a large organization and
17 you actually had CDC people helping with that
18 effort.

19 There's a sustainable
20 transportation organization. I can send your
21 Committee some of the specifics, because I had
22 my antenna out there for all the many

1 different organizations that are doing
2 indicator projects on the social determinants
3 of health just to see where they're at and
4 what they're doing.

5 Many of these organizations
6 actually have a business model where they're
7 going to be doing these ratings, in part for
8 identifying interventions, specific
9 interventions that they can do. And when they
10 do contracting to various entities for
11 whatever, public works, that they actually
12 will have some of these indicators written in
13 that is per the contractual arrangement that
14 they're still going to somehow contribute to
15 the indicators.

16 So, there's actually a business
17 reason why some of these communities are doing
18 it. Much of it is influenced by the LEED, the
19 leadership in environmental design folks. So
20 there's other organizations I found out about
21 as well. But I can send those to the
22 Committee afterwards.

1 CO-CHAIR JARRIS: That's very
2 helpful. In fact, that's something that NQF
3 might want to consider is that competitive
4 analysis of who else is in this space that can
5 be collaborators or competitors.

6 Sarah, you are on the line and
7 wanted to say something. And so, Operator, if
8 Sarah Linde-Feucht's line is not open, can you
9 open it?

10 OPERATOR: One moment.

11 CO-CHAIR JARRIS: Perhaps while
12 we're waiting, we'll go Bobby, Ron and Matt.

13 MEMBER PESTRONK: I was trying to
14 figure out what problem we're trying to solve.

15 OPERATOR: Sarah, press star 1.

16 MEMBER PESTRONK: Because before
17 Neil's presentation it seemed to me that we
18 were focused on three or four different
19 problems and that it would be helpful for us
20 to pick one and then continuous quality
21 improvement jargon do a fishbone diagram and
22 ask ourselves what's contributing to the

1 problem. And ask ourselves if NQF will go
2 forward in this space, what's our --

3 MR. CORBRIDGE: Thank you.

4 Ian Corbridge, can you hear me?

5 CO-CHAIR JARRIS: Yes. Who is
6 that, please?

7 MR. CORBRIDGE: This is Ian
8 Corbridge with HRSA. Apologize, Sarah Linde-
9 Feucht had to step off the phone, but she
10 asked me to speak in her stead. I don't know
11 if now is a good time to follow-up on some of
12 that or if you want to kind of reserve that
13 conversation until later on.

14 CO-CHAIR JARRIS: Why don't we let
15 Bobby finish and then ask you to speak.

16 MR. CORBRIDGE: All right.
17 Wonderful. I'll stay on the phone.

18 MEMBER PESTRONK: The four
19 potential problems, the four problems that I
20 heard were that we didn't get a sufficient
21 number of measures submitted; that's one
22 problem.

1 The second is that the measures
2 that were submitted were of poor quality, and
3 that had to do with that they were more
4 clinically focused or that they were not
5 social determinant focused.

6 The third problem is that there
7 was some confusion in the evaluation of the
8 submitted measures; that we had some
9 confusion.

10 And then the fourth problem was
11 the ability to get measures accepted by the
12 NQF Board.

13 So those, there were comments
14 about each of those. And those are very
15 different problems.

16 MS. MAINO-FIKE: May I interrupt
17 for just one second?

18 MEMBER PESTRONK: Yes.

19 MS. MAINO-FIKE: And ask you, I
20 want to make sure that we get those four
21 categories you've created. What was the
22 third?

1 MEMBER PESTRONK: The third was
2 confusion around how to evaluate the measures,
3 both on the part of submitters and on the part
4 of us as a Committee.

5 MS. MAINO-FIKE: Okay.

6 MEMBER PESTRONK: And so my
7 thinking is that if we were clear about what
8 problem we were trying to solve, then we would
9 do a better job of solving it.

10 MS. MAINO-FIKE: Right.

11 CO-CHAIR JARRIS: Our colleague
12 from HRSA, did you want to speak now? And
13 could you identify yourself again because
14 there was some breaking up of the phone there.

15 MR. CORBRIDGE: Yes. I apologize.
16 Can you guys hear me clear now?

17 CO-CHAIR JARRIS: Yes.

18 MR. CORBRIDGE: All right. So
19 this is Ian Corbridge with the Health
20 Resources and Services Administration filling
21 in for Captain Sarah Linde-Feucht. She
22 apologizes. She had to step off the phone,

1 but has been listening into the discussion
2 this morning.

3 And I think, Paul, with respect to
4 your question yesterday, I wanted to follow-up
5 on a couple of points where I guess you
6 pointedly asked why maybe more measures from
7 HRSA didn't come into this project. So,
8 having spoken with Sarah, I really wanted to
9 touch on two points that I think tie into
10 today's larger discussion really looking at
11 the commitments and investments into the NQF
12 process from HRSA and HHS' standpoint, and
13 then also I think hoping to touch on probably
14 the low response rate, specifically from
15 HRSA's perspective.

16 So kind of on the larger view it
17 is HRSA Administrator Dr. Wakefield's priority
18 not only to align measures and actual
19 specifications within the agency, but also to
20 make sure that we're doing it at the federal
21 level. And that's really tying into this
22 larger drive from the National Quality

1 Strategy. And so as that trickles down it
2 really is a priority of HRSA's Administrator
3 to make sure that all the bureaus and offices
4 within the agency are using nationally
5 recognized measures and really has moved us to
6 making sure that when we are using measures
7 within HRSA programs that we are using or
8 moving towards NQF endorsed measures. And so
9 that set us somewhat on a different trajectory
10 and has caused us to change some of the way
11 that we're doing business or thinking about
12 development and moving forward.

13 So, I think that is kind of a
14 strong commitment. And I would say that
15 probably resounds across HHS and really moving
16 towards the NQF process, more to I think
17 specifically decide probably the lack of
18 response rate, specifically from HRSA's end.
19 And I think this goes to issues that have
20 already been touched on, but I hope it kind of
21 provided a perspective from HRSA in the safety
22 net community. It's really an issue of timing

1 and resources.

2 I think we've already touched on
3 the timing to some degree, but given the
4 current NQF process and a cycle of every three
5 years of when the different measurement
6 projects come up, depending upon when an
7 agency or an entity has a measure ready and
8 depending on when that cycle starts, you may
9 have a measure that's ready but maybe you
10 haven't completed your testing or validation,
11 et cetera. However, if that project has
12 already started and you're not ready to
13 submit, you kind of lose out. You may have to
14 wait another three years. So I think there's
15 really an issue of timing.

16 With respect to this specific
17 project, I know there were entities or bureaus
18 and offices within HRSA who had intended to or
19 were interested in submitting measures to this
20 project. One of them specifically was HRSA's
21 Maternal and Child Health Bureau. However
22 their measures weren't tested and validated at

1 this time, and so they weren't able to submit
2 measures.

3 Another bureau that was interested
4 was HRSA's HIV/AIDS Bureau, but given the
5 actual kind of specifications and target of
6 their measures, they were encouraged to submit
7 their measures to the NQF Infectious Disease
8 Project which is coming up in a couple of
9 months.

10 So, those were the two bureaus
11 that actually had measures that were of
12 interest to this project, and I think wanted
13 to participate. One due to timing issues and
14 one due to a priority of their measures would
15 fit better in a different project. So it was
16 really due to a lack of response rate on
17 HRSA's end.

18 I will say that I think one
19 challenge is that the framework that the
20 Committee put out and the turnaround time
21 frame by which the measure development
22 committee had time to react to that was

1 relatively short. And I think when we looked
2 at the broader spectrum of measure
3 development, the field didn't really have the
4 time necessary I think to adequately pull
5 together something that would be of value for
6 the Committee to review.

7 So, I think from our end as we
8 looked at that framework I think it had a lot
9 of value to the agency and give us a lot of
10 direction of where we need to go. I would
11 imagine in a couple of years there would be a
12 point at which we would be ready to probably
13 move population health measures through.

14 That being said, I know I had a
15 conversation yesterday with respect to the HHS
16 Home Visiting Program which HRSA is helping to
17 run. And they have a wide variety of measures
18 that actually get to the health determinant
19 level that a representative from HRSA was
20 interested in moving through the NQF
21 endorsement process or having that discussion.
22 So, I know this project has already passed,

1 but I think at a later date when the
2 opportunity arises, we'd be very interested in
3 trying to move some of those more population
4 level measures through the NQF process.

5 That was some of the key points
6 that Sarah wanted me to speak on. I don't
7 know if there's any questions, or if that was
8 helpful to the conversation. But thank you
9 for the opportunity to speak.

10 CO-CHAIR JARRIS: Thank you. That
11 was very helpful.

12 From your point of view what could
13 be done to help HRSA by NQF in terms of
14 preparing as an agency or parts of the agency
15 to develop and submit measures?

16 MR. CORBRIDGE: Again, I think one
17 of the challenge on HRSA's end is that we have
18 very limited expertise in terms of actual
19 measure developers within the agency itself
20 and really try to leverage off of already
21 developed and endorsed measures. That being
22 said, we really do look to develop measures

1 when there are gaps, when we have identified
2 gaps.

3 And one thing that I think we
4 would find helpful, I know these conversations
5 are already taking place, is looking to
6 somewhat revamp or restructure the current NQF
7 endorsement process. And I don't know, maybe
8 Helen or others from the NQF staff in the room
9 can speak on that issue. So really trying to
10 make it a much more nimble process that can
11 respond to change in guidelines or best
12 practices within the field.

13 I will say having recently had a
14 discussion with the NQF staff around the NQF
15 Infectious Disease Project, we found it very
16 helpful in that NQF staff actually took the
17 time about an hour and a half and they sat
18 down with the actual developers within HRSA
19 and some of the team that I work with and
20 really went through all the steps within the
21 NQF endorsement process, were very detailed in
22 helping us to think through some of the

1 testing requirements, that we had our testing
2 data in order to submit to NQF. So, I think
3 that process was invaluable for us and I think
4 that that's something that hopefully the rest
5 of the measure development community can
6 really take advantage of.

7 DR. BURSTIN: Just briefly to
8 respond to what Ian is referring to. We are
9 actually moving towards our pilot, just
10 approved yesterday actually, a two stage
11 endorsement process. And some of this is to
12 try to make our work align better with the
13 work of measure development. So that we're
14 going to be moving forward, probably in 2013,
15 across all projects with a process whereby
16 measures would come forward as a concept first
17 and really just get a look at importance to
18 measure and report. So really looking at the
19 impact, where there's a gap, the underlying
20 evidence and really the concept without the
21 requirements for the full testing and the full
22 specifications. If that's approved, the

1 developer can then come back with fully
2 specified tested measures.

3 So in the instance that Ian just
4 mentioned that there are measures out of MCHB
5 that might have been very appropriate but were
6 not tested, that would be an opportunity for
7 them to at least get an early read by a
8 Committee as to say whether they are important
9 enough to keep moving forward, and then bring
10 them back when they're tested. So try to make
11 it more nimble.

12 We're also going to move to having
13 we hope more regular submissions, at least on
14 an annual basis across all the different
15 topical areas.

16 DR. MAIZLISH: Hi. This is Neil
17 Maizlish again.

18 I have maybe two questions which
19 are related. One is, you know The Robert Wood
20 Johnson University of Wisconsin County Health
21 Rankings has come out. Are folks aware of
22 that project?

1 CO-CHAIR JARRIS: Yes, we are.

2 DR. MAIZLISH: Oh, okay. And I
3 don't know, did you have contact with them?
4 Because to me they seem to have a development
5 process that meets many of the criteria and
6 rigor that NQF has stated for developers. So,
7 that's one thing.

8 The other is has NQF ever
9 facilitated contacts between developers that
10 might advance the field in some way?

11 DR. BURSTIN: We routinely do
12 outreach. In fact, we did outreach to all
13 those groups, including Wisconsin. Again, I
14 think it was just an issue of people being
15 ready.

16 It is actually very helpful that
17 some of you may know Barb Rudolph, who has
18 been a measure developer of Leapfrog for
19 years. Barbara just joined David Kindig's
20 team. So I think having somebody on site --

21 DR. MAIZLISH: Okay.

22 DR. BURSTIN: -- who is very

1 familiar with development and NQF submission
2 actually will be very helpful as well.

3 DR. MAIZLISH: Okay.

4 MEMBER BIALEK: Just a quick
5 response to that last comment. Gets back to
6 again, you know what's in it for the
7 organization to propose the measure?

8 I know that we had with the
9 Community Health Status Indicators, we had a
10 whole process, evidence-based indicators.
11 Some of those indicators, county health
12 rankings. And we thought about, you know why
13 would we want to go through the process and
14 also do we have the resources to go through
15 the process. That second part was no, the
16 second question.

17 I fully support what Bobby
18 suggested is that we decide on which problem
19 to address. And I'd like to suggest that we
20 address the problem of too few measures. And
21 that we look at the root causes around that.
22 We identify then what it is that this

1 Committee and staff control and influence and
2 work on that.

3 At the same time, we identify what
4 other players may control or influence that
5 may be important. I think we can only address
6 what it is that we have the authority and the
7 ability to address. And so refining what
8 we're talking about and getting to the root
9 cause, and working that through I think would
10 be helpful.

11 Just one last item. Just a
12 question. Has the Institute for Health Care
13 Improvement submitted measures? They have.
14 Okay. Because I think about a lot of the
15 process types of measures that we might
16 ultimately look at from the public health
17 community that IHI has some process measures
18 that are clearly tied to health care, and we
19 can have process measures that clearly can tie
20 to health.

21 DR. BURSTIN: It's actually
22 interesting. IHI, HRSA, CDC all submit

1 measures to NQF but they're just clinical. I
2 mean, they are just much more -- not so much
3 clinical, but health care system focused. So
4 they're used to submitting, just not in this
5 area.

6 MEMBER STOTO: On that last point,
7 IHI of course has their Triple Aim activity
8 and it would seem to be the population health
9 leg of that tripod would be the right one to
10 work on.

11 But I wanted to pick up on the
12 last comment that was made on the phone about
13 the possibility of providing technical
14 support. I think it goes beyond what you were
15 responding to -- your response, Helen.

16 I mean, it strikes me that a lot
17 of people in the public health world are not
18 used to this measurement process, measure
19 development process that we're now used to in
20 the health care world. And that maybe a kind
21 of training session, you know what exactly is
22 involved? What are we talking about here?

1 How do you show that it works and so on and so
2 forth would be a useful thing to do.

3 MEMBER QASEEM: Okay. So I was
4 just sitting over here again with the
5 population health measures, I was trying to
6 figure out how we can differentiate a little
7 bit. In my mind, I don't think this is just
8 structured process outcome measures, and I was
9 just trying to list some of them from the top
10 of my head what I remembered over the years.

11 So population health measures fall
12 in the category of process, outcome, access,
13 structure of course is there, population
14 experience, population management, population
15 costs and population services.

16 And I don't think that we can have
17 them, we can separate them out, sort of linked
18 to what I was trying to say earlier as all the
19 population needs to be looked as a whole.

20 So, for example, we'll take an
21 example of smoking. We talked about some of
22 the process and outcome measures, but we can't

1 separate out for example population experience
2 which I think is whether the population has
3 seen ads on TV or ads in papers regarding
4 anti-smoking.

5 Population access would be access
6 to smoking cessation programs. Costs, of
7 course, we all know. And then population
8 services is going to be whether the population
9 is using those services.

10 And again, I think that maybe NQF
11 when we go out and make the call for measures,
12 I think we need to be really looking at all of
13 them together. We just cannot be getting
14 measures getting measures that are talking
15 about population process and population
16 outcomes if we are not really talking about
17 the rest of these categories. Because again,
18 it goes back to the if you're talking about
19 improving the care and outcomes for the
20 population level, if you're addressing just
21 two out of whatever, seven or eight, then very
22 bright people have done work on this, it's not

1 going to improve the health of the population
2 unless we take them altogether and come up
3 with the measures that sort of -- it goes back
4 to sort of a composite measure sort of thing.
5 But it's difficult, but I think this is where
6 NQF can play a leadership role in terms of
7 specifically asking that it may be better to
8 just have a performance measures on smoking
9 cessation that addresses some of these
10 categories rather than having 20 measures that
11 are just talking about one here and one there.

12 MEMBER STIEFEL: Sorry this is a
13 little disjointed. My card went up when Peter
14 was talking.

15 But along the way, just in
16 response to Mike's comment, I serve on the IHI
17 Triple Aim Faculty for Measurement and have
18 developed the population health measures for
19 the Triple Aim. Those have been submitted to
20 Health Affairs, including the framework that
21 I developed and that's the status of that
22 work.

1 I would say in general it's not so
2 much IHI's philosophy to have the same level
3 of rigor for the measurement work, especially
4 for quality improvement that are established
5 for NQF endorsed measures.

6 The comment, I have sort of an
7 observation and specific recommendation. The
8 observation is based on the interchange
9 between Peter and Helen in talking about the
10 potential value of standardization and
11 harmonization. And I think that the sweet
12 spot for this work and for NQF is at the
13 intersection between health care delivery and
14 public health and not too far out in the
15 middle of the public health, but at that
16 intersection. And I think that the sweet spot
17 for that intersection is in the measures of
18 health behaviors. Again, back to smoking,
19 eating, drinking and exercise.

20 There's mutual benefit in the
21 public health world. The problem is that
22 those are assessed in small random sample

1 surveys that are getting worse and worse over
2 time because of response rates and people not
3 having forms and all that. And those measures
4 are not useful to the health care delivery
5 system. The county health rankings are not
6 very useful to the health care delivery system
7 because they're not discrete enough; they
8 don't go down to the level where improvement
9 happens. But those measures are increasingly,
10 routinely collected, gathered in the health
11 care delivery system and by health plans.

12 And so it's interesting. The
13 clinical care delivery system has
14 subpopulation level data of entire
15 subpopulations whereas the public health
16 system has these small random sample surveys.

17 So if measures in those domains,
18 and just take those four behaviors, were
19 standardized or harmonized such that the
20 measures that the clinical care delivery
21 system is gathering for subpopulations are the
22 same measures with the same specifications as

1 the public health measures, then we can move
2 toward rolling up those subpopulation measures
3 to get at least approximations of total
4 population measures. And with that I think
5 that will drive I think the behavior that
6 we're interested in. I think that there's a
7 positive feedback, a synergy in that having
8 better information on those healthy behaviors
9 in the public health world will drive
10 improvement activities probably upstream in
11 social and environmental determinants. It
12 will drive improvement activities in the
13 health care delivery system because the health
14 care delivery system is, at least my
15 organization and I'm sure Sarah's as well, get
16 it that smoking and drinking and eating and
17 exercise are profound determinants of
18 subsequent utilization in costs and outcomes.
19 So it will drive the improvement activities in
20 the kinds of things that we were talking about
21 yesterday about assessment and then follow-up.

22 So by focusing on that sweet spot

1 I think that we will generate activity in this
2 positive feedback loop in both public health
3 and the clinical care delivery system, and it
4 seems like a very appropriate role for NQF to
5 focus on defining clearly in harmonizing the
6 measures used in public health and clinical
7 health.

8 You can then go beyond the health
9 behaviors. I mean, we've got great
10 information on disease status with our disease
11 registries. That could be rolled up to
12 population level measures. Or even self-
13 perceived health down the road. We routinely
14 collect that information now. If that's
15 measured in the standard way and there's an
16 easy way to standardize that, that also could
17 be rolled up from the subpopulation.

18 So it's just the point is that
19 it's at that intersection. And I think that
20 a modest first step would be to focus on those
21 four healthy behaviors and do a call for
22 measures, specifically for those. And I think

1 make the case that there's mutual benefit to
2 public health and health care delivery.

3 CO-CHAIR JARRIS: Kurt?

4 CO-CHAIR STANGE: This is really
5 just a minor point, but just s reaction to
6 Mike's comment. I actually like the idea of
7 an educational thing that NQF could do on
8 population health measures. And the addendum
9 I want to make of that is to think of it as a
10 two-way learning street. Because I think one
11 small hook might be the idea that people
12 getting that education could actually help
13 frame, influence NQF's thinking in this area.
14 I mean, when people are too busy to really
15 come up with the measures, it might not be
16 enough of a motivation. But for some it might
17 be a little bit of a motivation, particularly
18 for things that are -- I mean clearly the role
19 I think we're hearing for NQF is really at the
20 interface with the clinical care measures.
21 And I agree with Matt that the healthy
22 behaviors are a nice way to frame it. But

1 just think about an educational thing as a
2 two-way street and that would be a good frame.

3 MEMBER STOTO: Yes, I think that's
4 right. And I think that over the last,
5 whatever decade or so that NQF has been
6 around, that has all happened. But it hasn't
7 happened with the public health community.
8 And we have to short-circuit that.

9 CO-CHAIR JARRIS: So I just wanted
10 to add one thing to just put it on the list
11 and it doesn't even have to be addressed
12 today. But the notion of evidence and what is
13 considered evidence within this NQF process.
14 And I think it's largely been a biomedical
15 model. And yet when you get out into the
16 population public health world, you're talking
17 about a collection of different sciences.
18 There clearly are some biomedical science
19 components, but there are many social sciences
20 whether it's political sciences,
21 communications, economics, behavioral sciences
22 that have different types of evidence

1 gathering and different notions of what
2 evidence is. And I think that's going to be
3 a tremendously difficult thing as we start
4 moving away from purely clinical measures into
5 public health and population interventions to
6 decide what is adequate evidence. Because if
7 we use the random double-blinded controlled
8 study, we're going to get nothing. It just
9 does not apply in that world. So somehow we
10 need to figure that out and come up with an
11 acceptable level of what constitutes evidence.

12 So, I guess, Kurt, you were going
13 to say something and then let's take a break.

14 CO-CHAIR STANGE: I don't know if
15 Peter's still on, but certainly piggyback onto
16 the work that the Community Guide folks have
17 done and having to think about that makes
18 sense.

19 CO-CHAIR JARRIS: But even the
20 Community Guide, by the time you get into
21 Community Guide you're ten years into a
22 process because it has to collect so much. I

1 mean, you can't drive innovation with a
2 Community Guide. You're driving
3 retrospectively.

4 DR. BURSTIN: One last point. We
5 did some work on an evidence task force about
6 a year and a half ago or so and had a very
7 nice report some experts did for us on how to
8 assess evidence. We don't require double-
9 blind RCTs. It's very clearly that we ask to
10 look at the quality and the quantity and the
11 consistency of evidence. So there could be a
12 very new single study that's really innovative
13 and really important and there's no evidence
14 of inconsistency, and that can move things
15 forward. I mean if you look at the work we
16 just did on cultural competency or care
17 coordination, I'm not convinced it's that
18 different than the evidence base for some of
19 these public health interventions. They're
20 actually -- we had lots of discussions about
21 squishiness of what's really there, but they
22 still moved forward because everybody agreed

1 that those were important enough. And we
2 actually have an evidence exception. If
3 something is so important that everybody in
4 the Committee completely agrees that this
5 would drive significant improvement and the
6 evidence just isn't there, it's not that the
7 evidence is there and it's negative, it just
8 isn't there at all, the Committee can still
9 move it forward. And we've done that, for
10 example, some work on spirituality in
11 palliative care. Again, not something you're
12 going to see a ton of research on, but then
13 why would anybody say don't move something
14 like that forward when it's so intuitive that
15 that would be useful for patients?

16 MEMBER STIEFEL: I agree. You
17 know, I think science is science. And I think
18 it applies more broadly, especially if you
19 don't necessarily require specifically
20 clinical trials.

21 Where we stumbled yesterday was
22 evidence base associated with these

1 assessments that -- because it's a long way
2 causal pathway between assessing something and
3 the outcome. But for BMI, for example, so
4 assessment of BMI it was troublesome, in fact
5 we rejected them yesterday. But if the
6 measure was BMI, that causal pathway is very
7 clear between BMI and outcomes. I don't think
8 we would have had any trouble at all of making
9 the association and thinking that the evidence
10 was there.

11 MS. MAINO-FIKE: I think that
12 sounds good.

13 So let's take a ten minute break
14 because what that usually means is it's a 15
15 minute break. So let's take ten minutes and
16 get back at five of and we can wrap up our
17 discussion and we'll be done at 11:45.

18 (Whereupon, the above-entitled
19 matter went off the record at 10:41 a.m. and
20 resumed 11:04 p.m.)

21 MS. MAINO-FIKE: So let's
22 summarize what we've accomplished thus far

1 this morning.

2 It seems that there was a lot of
3 energy in having a broad discussion on not
4 just why we had a low response to the call for
5 measures, but on some larger issues as well.
6 So, we spent a good amount of time gathering
7 very important observations and feedback
8 regarding not just the call for measures, but
9 a possible role for NQF in moving forward with
10 not just clinical measures, but public and
11 population measures and the need for some
12 consistent standardization in that area. And
13 it seems like this is really a point in time
14 where the health field has evolved to where
15 you're looking at putting some more rigorous
16 and standardized measures and bringing that
17 out into the population or public health care
18 forum.

19 What seemed to me in listening to
20 the discussion was that three categories
21 seemed to emerge around your conversation.
22 One category was simply why was the response

1 low? What were the determining factors in
2 those responses so low? And I've identified
3 and captured some of the comments under No. 1
4 for that.

5 The second category of broad
6 comments seemed to be what are some future
7 steps or needs that NQF, perhaps this group,
8 might want to look at? Not that there are
9 decision points there. Some of those possible
10 future steps are small, some of them might be
11 larger and broader in scope.

12 And then the third category of
13 comments seemed to be around the measures
14 themselves. Okay. And I've captured those
15 under category No. 3.

16 Someone asked, obviously my
17 chicken scratch is exactly that; chicken
18 scratch, hard to understand. I've tried to
19 post things in terms of category 1, category
20 2, category 3. However, one of the outcomes
21 of this meeting is that each of you will get
22 not just the meeting minutes, but the lists of

1 the comments and suggestions in each of those
2 categories so that we don't lose them.

3 What we thought it might be good
4 to do now in the remaining 45 minutes or so is
5 to bring the conversation down to a more
6 concrete level given all of the excellent
7 input and discussion we've had up to this
8 point. So what we'd like to do is a fishbone
9 diagram. I don't know, some of you may have
10 used that format in the past regarding
11 bringing it to the original purpose for the
12 morning, which is we want to frame it in a
13 more positive way. Not why, you know was the
14 response so low. But assuming that we're
15 going to reissue this call for measures, what
16 should we -- would we do differently? So
17 let's keep it on a more positive frame of
18 mind.

19 So, here's our assumption that we
20 will reissue this call for measures. What
21 would we do differently?

22 Some of you have come up earlier

1 this morning with some categories or areas
2 around what you might do different, and that's
3 fine if you want to identify categories. I
4 think we can kind of brainstorm some of these.
5 And if I'm not clear on what the connections
6 are, you can certainly correct me so that
7 they're reflected appropriately on the
8 fishbone diagram. And then that might lead us
9 just very naturally into a conversation which
10 you'll see next on the agenda, the working
11 lunch regarding measures.

12 So, assuming we are going to
13 reissue this call for measures, what would we
14 do differently?

15 I'm sorry. I can't see the name
16 tags being flipped up, I apologize, when I'm
17 over there. Matt?

18 MEMBER STIEFEL: That's okay, I
19 was just waiting for permission.

20 MS. MAINO-FIKE: Maybe we can do
21 the hand raise thing because it's easier to
22 see from up there.

1 MEMBER STIEFEL: Well, I think I
2 might challenge your premise.

3 MS. MAINO-FIKE: Okay.

4 MEMBER STIEFEL: If we were to do
5 another call for measures, what would we do
6 differently?

7 MS. MAINO-FIKE: Yes.

8 MEMBER STIEFEL: Maybe take out
9 the front part of that, just what would we do
10 differently.

11 MS. MAINO-FIKE: Yes.

12 MEMBER STIEFEL: Because I think
13 part of the problem was in relying on luck of
14 the draw about whoever happened to submit
15 measures.

16 MS. MAINO-FIKE: Yes.

17 MEMBER STIEFEL: And it turned out
18 there was a handful of clinical improvement
19 measures that we got. So it seems like we
20 shouldn't rely, at least at the front end, on
21 a call for measures but instead Helen and I
22 were talking a little bit on the break about

1 doing an exercise of finding -- going out now
2 and finding all of the sources and pick a
3 subset. You know, pick behaviors is my
4 suggestion. But do an analysis of all of the
5 public health measures for those health
6 behaviors, all of the measures used within the
7 clinical care delivery system, and they are in
8 HEDIS and other sources. And do a kind of
9 harmonization exercise and maybe even -- I
10 don't know if it's a white paper or whatever,
11 but come up with some recommendations. And
12 then from that, perhaps, go and solicit. And
13 maybe that's the call for measures part. But
14 you'd be soliciting to particular developers,
15 say here's our framework, we would like you to
16 submit a measure in this area.

17 The second part is, Jason and I
18 were talking at the break also about there are
19 a lot of population or potential population
20 health measures currently in the NCQA and NQF
21 portfolios. They're just not labeled
22 population health measures. But it would be

1 an interesting exercise just to assemble all
2 of those into a compendium or a collection of
3 potential population health measures. And
4 again start from there to do a more informed
5 targeting. And maybe it's a different type of
6 call that's done for measures when that
7 groundwork is done.

8 MS. MAINO-FIKE: Okay. So what I
9 have here is this bone, if you will, of
10 identifying sources, recommendations and
11 basically solicit targeted developers rather
12 than just sort of throwing it out there to
13 anyone and everyone. So, one might be to
14 solicit targeted developers.

15 And then the other is to survey
16 population health measures that are already
17 out there and compile them in some sort of a
18 list so that you don't have to reinvent the
19 wheel.

20 MEMBER STIEFEL: Before
21 solicitation, though, I think that's an
22 important piece of it; that's the analysis of

1 the existing measures that are already out
2 there and where there are similarities and
3 differences. And so that's an important
4 analytic piece that I think could be done now
5 and would be valuable.

6 MS. MAINO-FIKE: And help me. Am
7 I not capturing that properly here? Identify
8 resources, recommendations in order to solicit
9 targeted developers and then survey population
10 health measures and compile them? Is the
11 second step analysis of that?

12 MEMBER STIEFEL: The first step is
13 to kind of assess the state of measurement in
14 targeted domains.

15 MS. MAINO-FIKE: Okay.

16 MS. NISHIMI: I just want the
17 Committee to be aware that actually as part of
18 the discussion for this afternoon that this is
19 bleeding into, the staff did look through the
20 existing portfolio and have identified the
21 "population health measures." And so that is
22 available and we can tee that up for everyone

1 to take a look at.

2 MS. MAINO-FIKE: Good.

3 What else should show up on that
4 fishbone diagram? Yes?

5 MEMBER BIALEK: I'd like to offer
6 a few broader categories and then some
7 specifics underneath at least one of them.

8 MS. MAINO-FIKE: Okay.

9 MEMBER BIALEK: I think we need to
10 refine the guidance that's provided to those
11 we wish to submit measures.

12 We need to reduce the burden for
13 those who wish to submit measures.

14 And we need to demonstrate the
15 value to those who wish to submit measures.

16 Under refined guidance --

17 MS. MAINO-FIKE: I'm sorry. One
18 thing.

19 MEMBER BIALEK: Yes.

20 MS. MAINO-FIKE: So refine
21 guidance, reduce the burden for those
22 developers --

1 MEMBER BIALEK: And demonstrate
2 value.

3 MS. MAINO-FIKE: Demonstrate
4 value.

5 MEMBER BIALEK: Yes.

6 Under the guidance, I'd like to
7 suggest that the work sheet be reworked to
8 incorporate the specific population health
9 measure language that we came up with during
10 one of our earlier meetings. Well, the
11 language that's on the -- what are these
12 called? The criteria, right. That it
13 actually use the language versus the health
14 care language.

15 Second, that to the extent
16 feasible we provide some examples of completed
17 work sheets to help people see the types of
18 information that's desired.

19 And then third, I think a couple
20 of folks mentioned that education, webinars,
21 whatever it might take to help engage people
22 in a dialogue to help build some

1 understanding.

2 The last piece I'll mention has to
3 do with the burden. I think part of the
4 burden was the time frame, not just the time
5 it took but how much time people had that they
6 could devote to this within -- you know, to
7 get the measure submitted. And so I think --

8 MS. MAINO-FIKE: Deadline for
9 responding?

10 MEMBER BIALEK: Yes, right. So, I
11 think increasing the time frame, the
12 responding that's under that.

13 MS. MAINO-FIKE: Yes.

14 MEMBER BIALEK: And I'll stop.

15 MS. MAINO-FIKE: Okay. Well, what
16 I've added up here is refine our guidance;
17 that's something that we can do differently
18 whenever we issue a call, let's put it that
19 way.

20 We can revise the work sheet to
21 use the recommended language that's indicated.

22 Provide examples for our

1 developers.

2 And provide some sort of training
3 or education for developers to allow them to
4 have a more informed dialogue on this, and see
5 what the value might be of participating.

6 The other thing you said was to
7 reduce the burden for our developers. And one
8 way to do that is to increase the time that
9 they have that they have to meet the deadline
10 to respond. Okay.

11 And then the other thing that you
12 said was we need some way to demonstrate the
13 value and it's the value to our developers of
14 responding.

15 MEMBER STOTO: I'd like to develop
16 that a little bit further. I mean, I don't
17 think it's so much demonstrating it. I think
18 we have to be clear what it is. I don't think
19 that we know what the value proposition really
20 is here.

21 MS. MAINO-FIKE: Yes.

22 MEMBER STOTO: I mean, it's kind

1 of evolved over time for the health care world
2 in NQF --

3 MS. MAINO-FIKE: Yes.

4 MEMBER STOTO: -- but in the
5 population health world I mean it seems to me
6 we have to begin to by thinking about what are
7 the potential users and uses of these
8 measures. And the ones that have been on the
9 table are the IRS community benefits, the
10 accreditation standards, the accountable care
11 organizations and things like that. And that
12 I think that if we thought through what are
13 the potential uses, and then I'm sure there
14 are more than those. The IHI Triple Aim is
15 another one that we put in there. That would
16 lead to more clearer thinking about what is
17 the potential value of having IHI -- what do
18 you call this organization? NQF endorsement.
19 Excuse me. I'm sorry. NQF endorsement.

20 MS. MAINO-FIKE: Right.

21 MEMBER STOTO: And it seems to me
22 that there are two possible values with that.

1 One is the harmonization that
2 comes from that process, and the other one is
3 the sense that these are good measures. I
4 think that those things may play out
5 differently in public health than in the
6 health care world, population health.

7 MS. MAINO-FIKE: Okay. So let me
8 just tell you what I've captured. So not only
9 do we want to demonstrate the value, but we
10 need to actually create what that value
11 proposition is or articulate it. And then we
12 can demonstrate it or communicate it, or try
13 to engage people in getting on board with what
14 that value proposition is.

15 And you put forth two pieces of --

16 MEMBER STOTO: And I guess what I
17 would say is that in order to do that we have
18 to consider what are the potential uses and
19 users --

20 MS. MAINO-FIKE: Yes.

21 MEMBER STOTO: -- of NQF endorsed
22 population health measures.

1 MS. MAINO-FIKE: Okay. Including
2 uses and users potential. All right. Very
3 good. Very good.

4 I know someone over here -- yes?
5 Matt?

6 MEMBER STIEFEL: And I think that
7 value proposition to public health is with
8 harmonized data available from the health care
9 delivery system it would dramatically improve
10 the public health surveillance system that
11 relies currently on these small dwindling
12 random sample surveys. That's it. And I'm
13 not sure if that message is clearly made or
14 understood, but it seems potentially
15 enormously valuable. I don't think public
16 health has any idea about it.

17 MS. MAINO-FIKE: So let me put
18 this in some sort of an equation. So you said
19 harmonized standards from your health care
20 delivery systems results in improved -- you
21 said "surveillance of public health." Is that
22 the best word?

1 MEMBER STIEFEL: I would say so.

2 MEMBER STOTO: I would say
3 assessment; that's one of the three core
4 public health functions that includes all this
5 stuff.

6 MS. MAINO-FIKE: Okay.

7 MEMBER STIEFEL: Because it's a
8 much richer data source.

9 MS. MAINO-FIKE: Okay. So that's
10 one possible value equation. There might be
11 others that you choose to use as well.

12 I want to ask some folks who have
13 not put forth some ideas. I want to make sure
14 everybody gets a chance to participate.

15 MEMBER STOTO: Okay.

16 CO-CHAIR JARRIS: So there's two
17 things I want to say. One is that Helen
18 mentioned a two step process, perhaps, and
19 maybe this would be an excellent place to
20 start to basically say have a phase of this
21 where you could put forth a concept. Is this
22 what you're thinking of? Is this what you're

1 talking about? And then to sort of work that
2 through so people can then decide whether or
3 not it's something that they should go back
4 and work on or perhaps it gets referred into
5 another group of NQF.

6 I think it would be very helpful
7 since people don't quite know what we're
8 asking for, and sometimes I think we don't
9 quite know what we're asking for based on what
10 we put out.

11 And then the other thing, I think
12 we should build out. I don't really think
13 that this is just a matter of educating
14 people, and I mean education and training are
15 components to it, but I think we have to have
16 a much more interactive process to support the
17 learning and development in this area. So, I
18 think it would be very interesting.

19 Remember, we heard basically we
20 don't have the time, we don't have the
21 resources to do this; that's a problem. So
22 how do we support that? And part of that

1 could be to look for seed funding to help
2 certain developers develop these measures if
3 there is no other funding out there. But part
4 of that also is to create some kind of
5 community of learning whether that's through
6 periodic calls or SharePoint sites or
7 something where we could bring together people
8 in the field to ask questions about well
9 here's the direction we're going in, what do
10 you think.

11 MS. MAINO-FIKE: Right.

12 CO-CHAIR JARRIS: And other
13 developers and other people in this area could
14 say, "Well, have you considered this, have you
15 considered that, we tried that, didn't work,"
16 whatever.

17 So, create a much more active
18 learning community.

19 MS. MAINO-FIKE: Yes.

20 CO-CHAIR JARRIS: Because it
21 sounds like we have to do a lot of development
22 here.

1 MS. MAINO-FIKE: A community of
2 practice is how I've heard that referred to.

3 DR. BURSTIN: And actually,
4 building on that I was actually going to say
5 something similar.

6 One of the things that really
7 struck me as well is I think there's a real
8 opportunity as well to work with the measure
9 developers who understand how to do this and
10 know NQF in a different way.

11 So, for example, I was struck by
12 the measures that we talked about yesterday
13 about physical activity. Granted, they were
14 inside the box, but start thinking about how
15 you take out some of those layers. If you
16 took out the requirement that they been seen
17 once a year, that gets a little bit further.
18 If you take out the requirement that they --
19 you know have to talk to a physician, that
20 gets it a little bit further. I mean, there
21 are ways to work with the current developers
22 I think as well to change their mindset.

1 Because they know how to do this.

2 And interestingly, you know NCQA
3 has been doing just as one example a lot of
4 the work developing the measures for Medicaid.
5 So they're out there developing, the same
6 folks who have been developing measures
7 traditionally in the health plan world are now
8 developing measures that have really no direct
9 connection back but are for Medicaid plans.

10 So, I think there's an opportunity
11 there to really build that community that's
12 the current measure developers with the folks
13 in the population health space and see if
14 there's some shared learning and opportunities
15 for a little marriage --

16 MS. MAINO-FIKE: And does that tie
17 into your initial thought around throwing a
18 concept out there for developers to react to?
19 When you said that --

20 CO-CHAIR JARRIS: Well, there's
21 two sides. Yes, we could do that. We could
22 put out concepts, that would be very helpful.

1 But I also think we ought to have an
2 opportunity for developers to throw a concept
3 in to say is this the type of thing that would
4 work.

5 But I just want to do one little
6 tweaking though here. This is not a matter of
7 just going to the public health folks and
8 population health folks and saying, "Wait a
9 minute, you guys don't get this. Let's help
10 you get it." This isn't gotten at all on the
11 clinical side, so we have to work there also
12 and somehow bring these things to -- and I
13 would agree with something you said earlier,
14 Matt. Probably the first place to work on is
15 the overlap of those two. The overlap may not
16 be appreciated by either side as much as it
17 needs to be.

18 MEMBER STOTO: If I could just add
19 one little point to this. I mean, I was
20 struck, I was saying to Ron during the break,
21 that here we're talking about measure
22 developers. If you want to an APHA meeting

1 and said we're going to have a reception for
2 all the measure developers, you'd have an
3 empty room because people just don't think of
4 themselves in that category. And I think
5 we've got to sort of build an identity in a
6 way.

7 MS. MAINO-FIKE: Yes. Good point.

8 Sue, are you --

9 MEMBER PICKENS: A couple of
10 things I wanted to bring up and I don't know
11 if this is an appropriate time or not.

12 One is we talked earlier about
13 what else is going out there in the field, who
14 else is developing all these measures, as Neil
15 talked about, there's lots of competition in
16 the field and suggested gathering that data,
17 who else is doing all those.

18 And then the other is is the
19 unusual partners that are out there doing this
20 work now. The Federal Reserve is going all
21 around the country doing the intersection of
22 health and economic and economic development.

1 They have had all these national conversations
2 going on.

3 And United Ways are getting really
4 involved in health improvement at the local
5 level. In our area they have a huge childhood
6 obesity initiative that they've involved the
7 entire community, all the health systems,
8 everybody involved.

9 CO-CHAIR JARRIS: The CIA tracks
10 comparative data between U.S. health and other
11 nations. I mean, it's amazing. That
12 competitive analysis is something I think we
13 should have.

14 MS. MAINO-FIKE: Yes. And I think
15 the competitive analysis that you're referring
16 to is a little bit different than developing
17 that community of interest.

18 CO-CHAIR JARRIS: Maybe we should
19 call it collaborative analysis or something
20 like that.

21 MS. MAINO-FIKE: Yes, yes.
22 Because, you know these aren't necessarily

1 your competitors. These are other folks that
2 might be operating in the space that NQF could
3 be in terms of interest in gathering measures.
4 So let's call it -- tell me what you had said,
5 the terminology?

6 CO-CHAIR JARRIS: The
7 collaborative analysis. I don't know.

8 MEMBER PESTRONK: Actually,
9 they're offering up the potential for measures
10 that could appeal to that space where public
11 health and clinical care overlap. And there's
12 no reason to go through the development
13 process, I think that's the whole point.
14 There's every reason for NQF to claim those
15 measures. There's no reason for NQF to have to
16 develop them all over again.

17 MS. MAINO-FIKE: Right.

18 MEMBER PESTRONK: Or to suggest
19 that they be developed. So it's creative
20 stealing for the purpose that NQF has been
21 asked to work in the population space.

22 MS. MAINO-FIKE: Right. And most

1 organizations would not view it as stealing or
2 competitive in anyway because it's furthering
3 something that they've already worked on. And
4 I think most organizations would view that,
5 would view the whole standardization issue as
6 you all have, as something that would be
7 positive.

8 Yes?

9 MEMBER STIEFEL: Well, a specific
10 suggestion about that, you know I think that
11 there's a lot of resonance about finding this
12 intersection or sweet spot between clinical
13 care and public health. I don't think -- this
14 may not be consistent with NQF's philosophy,
15 but it would be I think quite interesting,
16 perhaps, to convene a group of -- I don't
17 know. In public health I guess you don't call
18 them measure developers. but whatever they're
19 called in public health. And from clinical
20 care.

21 MS. MAINO-FIKE: Yes.

22 MEMBER STIEFEL: To get together

1 and focus on a few measures, and maybe it's
2 the health behavior measures, and that there
3 would be a background paper that would say
4 here are all the measures out there in public
5 health and clinical care. And the charge would
6 be to come up with a set of harmonized
7 measures that could be used in both domains
8 and to make the case for doing that.

9 So, it wouldn't be a call for
10 measures. It would be something different.
11 And I don't know if NQF does that, but it
12 would be an interesting exercise, I think.

13 CO-CHAIR JARRIS: Like a
14 datapalooza?

15 MS. MAINO-FIKE: Measurepalooza?

16 MEMBER STOTO: Yes. I think that
17 makes a lot of sense, and I would sort of
18 harken back to the discussion we had about the
19 smoking measures yesterday is that there's a
20 lot of people interested in smoking and
21 tobacco, different parts of CDC for different
22 surveys. If you look at the county health

1 rankings, they've got tobacco use in there and
2 so on. And I think that getting all of these
3 folks together with the people in the clinical
4 world who are interested in these topics to
5 kind of think through, you know, what is the
6 point of intersection and the way that -- the
7 measures are all out there, at least the
8 survey questions are all out there that we can
9 do a better job of harmonizing and things like
10 that would be a very useful exercise.

11 MS. MAINO-FIKE: Helen, is yours
12 up? It was just up from the last time. Okay.

13 Paul?

14 CO-CHAIR JARRIS: Well, part of it
15 would be convening is helpful, but the other
16 thing is outreach. I mean, you first got to
17 go to other people's table before you invite
18 them to your table. And that would be part of
19 this. Again, it's part of that collaborative
20 analysis. Who is out there in this world that
21 we should touch base with. And, you know,
22 there's certainly the APHA meetings which we

1 can give presentations and a workshop added on
2 to.

3 I think CSTE is -- Council for
4 State and Territorial Epidemiologists. If you
5 tweak them, they will fight you to the death
6 so you've got to make sure that you get in
7 with them the right way so they support this.

8 If you tweak them, in other words,
9 you know politically any group that's been
10 enlisted will be your ally. If they feel like
11 you are stepping on their toes, they are not
12 your ally. And with all due respect, the
13 epidemiologists they can argue to death on
14 anything if you want. But they're also
15 phenomenally powerful if we engage them. So we
16 should think about that as part of this
17 collaborative analysis: Who do we need to get
18 to, to talk, to enlist their help and support?

19 DR. BURSTIN: Right. So can we
20 continue that list? It would be actually
21 really useful just for the people in the room
22 just to throw out some of those organizations.

1 We engage the rest of the --

2 MS. MAINO-FIKE: Fine. Let's take
3 it aside. We'll do like a little break from
4 the fishbone exercise, okay, to just
5 brainstorm quickly in a couple of minutes who
6 off the top of your head or what some of those
7 organizations are out there that you might
8 want to include in this collaborative
9 analysis. Okay.

10 I can write them down here.

11 Maybe. Okay.

12 So we'll say collaborative
13 analysis, these are potential partners. Okay.

14 CO-CHAIR JARRIS: I'll give you
15 three: There's academic partners, funding
16 partners and practice partners will be three
17 main categories.

18 And I think funding partners just
19 might be the type of thing that RWJ would be
20 interested in. CDC should be interested.

21 AHRQ should be interested in it. So there's
22 a number of -- we heard that HRSA might be.

1 There's a number of groups like that that we
2 need to get to. Some of those are also
3 practice partners.

4 But FHA is one, CSTE, which is the
5 epidemiologists is one. I think the HIV
6 Association is one.

7 MEMBER STOTO: Well, focusing on
8 behaviors there's a group that deals with that
9 among the state health organizations. I forget
10 what that's called.

11 CO-CHAIR JARRIS: Yes. There's one
12 that deals with --

13 MEMBER STOTO: Chronic disease
14 probably is the --

15 CO-CHAIR JARRIS: Yes, chronic
16 disease.

17 MEMBER STOTO: Yes.

18 CO-CHAIR JARRIS: We convened that
19 group of 20 organizations on a quarterly
20 basis, so we could get you to all of them.
21 Some are going to be more powerful than
22 others.

1 I mean, then NACCHO has got to be
2 one of them, and you would have a world.

3 And I think maybe we should do --
4 we could do the email also, I mean to list
5 now.

6 MS. MAINO-FIKE: And brainstorm
7 this list via email? Okay. I mean, you don't
8 necessarily have to be together to do that.

9 All right. Let me ask you for
10 your third category.

11 CO-CHAIR JARRIS: Practice
12 partners. People actually in the field doing
13 the work, using the measures. They would come
14 in each of those levels, but under funding
15 they'd clearly be there's government and
16 philanthropic.

17 MS. MAINO-FIKE: You disagree,
18 agree; what are you thinking? Okay.

19 MEMBER STIEFEL: So, CDC, where
20 would CDC fit in?

21 CO-CHAIR JARRIS: Well, I would
22 hope they would be a funding partner, but they

1 also have many components of it that are in
2 the business and the practice.

3 MS. MAINO-FIKE: And that's an
4 example of an organization or a potential
5 partner that could fall under several of these
6 categories.

7 CO-CHAIR JARRIS: Right.

8 MS. MAINO-FIKE: I don't think
9 there's anything wrong with having --

10 MEMBER STIEFEL: There's a
11 category missing of -- I mean, they do a lot
12 of work in measure development which doesn't
13 fit neatly in one of those. What about
14 measure developers?

15 CO-CHAIR JARRIS: We've lumped
16 them in one of the practice group, but they're
17 also in academics and I mean, they're also --
18 I mean government -- or do we want to add
19 explicitly measure developers? But they do
20 actually fall in most of those categories. I
21 don't know what the word --

22 MEMBER PESTRONK: What's an

1 example that was just in your head about
2 someone in that category?

3 MEMBER STIEFEL: CDC and NCQA.
4 It's not only about public sector. I mean,
5 we're talking about the convergence, I think.

6 MEMBER BIALEK: I'm thinking a
7 group like RAND would not fit in any of those
8 three. So I don't know if it's academic or
9 research. Is that what you're thinking, more
10 research than --

11 CO-CHAIR JARRIS: Okay. Let's add
12 the category. Let's call them practice
13 developers then, for that matter.

14 MEMBER STIEFEL: Or just
15 brainstorm and then they fit the categories
16 after.

17 MS. MAINO-FIKE: I like "Other."
18 It leaves it broad. Okay.

19 MEMBER STOTO: But I would imagine
20 things like the folks of Wisconsin who do the
21 county health rankings and the Legacy
22 Foundation for the tobacco related things.

1 MS. MAINO-FIKE: Okay. So I'll
2 just put a few examples under each of these.

3 What's an example of an academic?

4 MEMBER STOTO: I would put
5 Wisconsin there.

6 MS. MAINO-FIKE: Oh, Wisconsin.

7 MEMBER SPANGLER: You can't
8 separate Wisconsin from RWJ. It's RWJ. It
9 just happens to be that the people that do the
10 work are Wisconsin. I mean, that's an RWJ
11 project now.

12 MEMBER STOTO: Yes. Sure. But we
13 really want the people who are doing the
14 collection work.

15 MEMBER SPANGLER: True. True. So
16 the reason I'm bringing that up is there may
17 be other people at RWJ that aren't affiliated
18 with the county health rankings that may also
19 be people we want to talk to.

20 MEMBER STOTO: Okay.

21 MS. MAINO-FIKE: Good point. Keep
22 your partners as broad as possible. I think

1 that's a good point.

2 MEMBER SPANGLER: We were talking
3 about before, and maybe we need to approach
4 them, but Healthy People. And I don't know
5 where they would -- no, that's ODPHP.

6 MEMBER SAMPSEL: But I also want
7 to throw out there when you're dealing with
8 Healthy People, when you're dealing with
9 Wisconsin, when you're dealing with -- or you
10 think about United does America's Health
11 Rankings and the Kaiser Foundation and all of
12 that, they're not developing measures.
13 They're using measures, you know because
14 county health rankings are using BRFSS for the
15 most part, right? So they can't submit those
16 measures.

17 MEMBER SPANGLER: They're
18 developing, they're indicators. But you can
19 easily make measures from indicators and
20 indices, I think.

21 MEMBER SAMPSEL: Yes, but they're
22 not really --

1 CO-CHAIR JARRIS: It sounds like
2 they're using publicly available data.

3 MEMBER SAMPSEL: I guess my point
4 is that they're using data from the CDC for
5 the most part. So they can't submit those
6 unless they do develop them into a measure.

7 MEMBER STIEFEL: I don't think we
8 should worry about categorization so much,
9 though as just getting the list of
10 organizations.

11 MS. MAINO-FIKE: Yes. Because you
12 may not at this moment in time see the obvious
13 tie-in or a direct tie-in for a potential
14 partner. But as you outreach to these people,
15 these organizations regardless of what their
16 role is, the ways to partner might become more
17 clear. So, I agree. Have this be a
18 brainstorming exercise for yourselves more
19 than anything else.

20 MEMBER SPANGLER: It seems like,
21 Sarah, though you weren't talking about
22 categorization, you were talking about should

1 they even be on the list, right?

2 MEMBER SAMPSEL: Yes. I mean, you
3 know to me some of the folks that were -- I
4 mean, I guess it all depends on what's the
5 use. You know, what is the purpose of the
6 list? If the purpose of the list is twofold:
7 one to engage the users of such measures, then
8 those folks fit. But if it's to engage people
9 to submit measures, they can't submit measures
10 they didn't develop or aren't measures in the
11 first place.

12 MS. MAINO-FIKE: And perhaps it's
13 both.

14 Ron, you had a comment?

15 MEMBER BIALEK: Yes. I'm not
16 really clear on the it. You know, we're
17 coming up with a list to do what?

18 MS. MAINO-FIKE: Okay. Well, this
19 is --

20 MEMBER BIALEK: Well, if I may, I
21 think if we try to do -- if whatever it is is
22 too broad and you list every conceivable

1 partner, nothing is going to get accomplished
2 and I would suggest that if there is a follow-
3 up, that one really narrow and look for some
4 type of an early win.

5 So if we look at every potential
6 opportunity for healthcare in public health,
7 we work together and to overlap. I mean,
8 there have been efforts in public health
9 initiatives and they've gone too far. And so
10 I'm just suggesting that maybe we --

11 MS. MAINO-FIKE: Well, here's a
12 question, a process question, because that was
13 a very goo question. So based on that a
14 process question for this group and this
15 Steering Committee.

16 So this exercise of identifying
17 potential partners in this collaborative
18 analysis or putting an initial list together
19 of potential partners; could be users, could
20 be developers -- well, you have a choice. We
21 can do a brainstorming here and use this time
22 here while you're together to do that. And

1 then perhaps a second step would be some
2 analysis to your point, Sarah and Ron, about
3 let's focus on some organizations that have
4 some clear solid links where we can possibly
5 develop some initial partnerships.

6 We can do that here using this
7 time, or that can be something that you choose
8 to do via email post-meeting. Remember, it's
9 one item on this fishbone diagram of what to
10 do differently when we are issuing a call for
11 measures, or whatever.

12 MEMBER PESTRONK: I thought it was
13 actually one of five potential in strategic
14 map language, strategic priorities that are
15 potentially available to address the problem
16 of two few measures were submitted. And the
17 broad category was identifying other measures
18 and use. And these are sources, these are
19 potential places where other measures are in
20 use now and it would be useful to ask them or
21 for someone to determine what measures do they
22 have in use that relate to the population

1 health work that NQF is doing.

2 CO-CHAIR JARRIS: I think you're
3 sort of talking about surveying the field for
4 what's out there. But as I stated at a
5 different level, I was thinking who are the
6 opinion leaders you want to enlist in terms of
7 collaboration or at least support who either
8 fund, develop or use measures. Because what
9 you don't want to do is ignore an important
10 group that then comes back and argues with you
11 or fights. I was talking about how do you get
12 the movement started.

13 MS. MAINO-FIKE: I was thinking of
14 your definition as opinion leaders as a part
15 of developing that community of practice. At
16 least I wrote that down as something as
17 something different from doing sort of what I
18 call an environmental survey of who is out
19 there that might have some standards in place,
20 more to your definition, you know the level of
21 partnership could be very different. So I see
22 those as two potentially different lists or

1 groups of organizations for you.

2 This is more an environmental
3 survey of what's out there versus your
4 community of practice, which are those key
5 partners and opinion leaders that you want to
6 make sure to involve.

7 MEMBER STOTO: Can I just report
8 that I'm scanning my emails and I got one from
9 another CDC oriented measuring project I'm
10 involved in all about an ASPE health systems
11 measurement project that has a population
12 health component, that has weight, smoking,
13 all sorts of good stuff in it.

14 MS. MAINO-FIKE: There you go.
15 There are other -- yes. Others out there.

16 So let's do this: Let's define
17 these two separate things. One is developing
18 or creating your community of practice. All
19 right. Those opinion leaders. And then the
20 other is doing a, we don't want to call it
21 competitive analysis, but an environmental
22 analysis if you will. So maybe we shouldn't

1 call it potential partners.

2 Do you want to look at just what's
3 out there already that we can use and build
4 on?

5 MEMBER PESTRONK: Go back to
6 what's the problem we're trying to solve. I
7 mean, are we trying to create a community of
8 practice and get a lot of other people working
9 in this area or are we trying to help NQF get
10 good measures submitted so that their
11 portfolio of measures is increased?

12 DR. BURSTIN: Just as follow-up
13 on, I actually wrote down what Paul said
14 because I found that incredibly helpful. So
15 if we think about sort of building on Matt's
16 idea of saying let's focus on a few of the big
17 ticket health behaviors, bringing together all
18 of the various entities in the clinical
19 community, in the development community,
20 public health community and what Paul said
21 which really resonated with me was you have to
22 outreach to other people's tables. And so to

1 me the question was who is out there who is
2 doing this work in the public health field who
3 we have probably never even talked to. We
4 talked to CDC, but I've certainly never talked
5 to CSCE or some of these other groups.

6 So, the thing for me was this was
7 this question of who is out there in this
8 space that if we were going to try to think
9 about convening like this, we want to make
10 sure we include so we don't wind up at the end
11 having missed a really important player in
12 this space.

13 MEMBER STOTO: Can I just add one
14 to that, the AcademyHealth, particularly the
15 public health systems research interest group.
16 I'm currently the Chair of that and we're just
17 beginning a project with RWJ funding about
18 translation about public health systems
19 research. I think it would be very --

20 MS. MAINO-FIKE: So who's out
21 there if we define this list? Who's out there
22 for us to partner with? And these broad

1 categories, academic, funding, practice
2 partners and other. It seems like there's
3 energy around brainstorming who and where
4 those partners might be. So is it something
5 you want to do now or do you want to do via
6 email later?

7 Helen, you think we're okay now?

8 Okay.

9 MEMBER QASEEM: So while we're
10 brainstorming this list of partners and
11 everything, and we love reinventing the wheel
12 in the U.S., there's been a lot of good work
13 that has been done in Europe. I'm sure many of
14 you are aware of it. In the United Kingdom
15 they implemented quality and -- QF framework,
16 I forget what --

17 MEMBER PESTRONK: Quality Outcomes
18 Framework?

19 MEMBER QASEEM: That's what it is.
20 And it happened and in fact they've been using
21 it for four or five years now. And they're
22 actually started seeing some negative

1 consequences at this point.

2 What started happening over there
3 was that the clinicians started focusing on
4 some of these measures and outcomes were from
5 some other performance measures, the other
6 things that should have been done that started
7 getting ignored.

8 And I'm not going to call them
9 partners or anything. And so in Germany, AZQ
10 have been doing some very good work in this
11 arena, has gone for a very long time and
12 they're way ahead of us.

13 And somehow I wonder if -- I don't
14 know how will this work, but I think if we can
15 engage some of these folks, at least learn
16 from their lessons, I think that would be more
17 helpful aside from what we're going to be
18 doing in the U.S. So rather than us being in
19 five years just going where they are at, maybe
20 we can take a little bit of a head start here.

21 MS. MAINO-FIKE: Very good. Good
22 point. Okay.

1 I'm looking at a time frame.

2 We're supposed to be breaking for lunch two
3 minutes ago. So we'll use ten more minutes.

4 So to kind of better define what
5 we're trying to come up with here, what are
6 the organizations that are out there that we
7 can richly partner with to get some quick
8 hits? A couple of under academic. Any others
9 under funding? I have CDC.

10 MEMBER BIALEK: Not necessarily
11 category, but folks who have thought about
12 this, the Community Indicators Consortium.
13 They look at broad community indicators, some
14 of which impact health, some of which impact
15 urban planning. It's a variety of approaches.
16 And I think they're Florida based. Well, I
17 know that some folks actually at NACCHO have
18 dealt with Community Indicators Consortium.
19 We've dealt with them.

20 MS. MAINO-FIKE: Any others you
21 can think of under practice partners?

22 MEMBER PICKENS: Outside the box

1 kind of partners like the Federal Reserve that
2 are trying to use this data in conversations
3 around the country and the United Way that are
4 developing projects and things. And doing
5 needs assessments all around the country.

6 MS. MAINO-FIKE: Any others?

7 MEMBER SPANGLER: I just had a
8 quick comment on what Ron -- sorry, I just
9 looked them up because I had never heard of
10 them. They have a integrating community
11 indicators and performance measures project.

12 MS. MAINO-FIKE: Oh.

13 MEMBER SPANGLER: So they're
14 trying to do what they do with performance
15 measures.

16 MS. MAINO-FIKE: Yes. So it
17 sounds like very similar objectives there.
18 Okay.

19 So let's record these as at least
20 an initial start to some partners that we'd
21 like to reach out to and see what they have,
22 what results they might already be doing.

1 MEMBER PESTRONK: Just to give you
2 an example, the group that Ron has just talked
3 about, the Community Indicators Project.
4 they've got a list of probably 300 communities
5 and organizations that have indicators as part
6 of their work.

7 MS. MAINO-FIKE: Yes. So to your
8 earlier point, there might be a lot of work
9 out there that does not require reinventing
10 the wheel on NQF's part?

11 MEMBER PESTRONK: Yes.

12 MEMBER BIALEK: The problem could
13 be that their indicators tend to be what we've
14 been referring to as the stretch indicators,
15 if you will.

16 MS. MAINO-FIKE: Right.

17 MEMBER BIALEK: That might not be
18 the ones that NQF would initially wish to
19 endorse. And so that's part of the rub.

20 What I thought Matt was suggesting
21 was starting with somewhere, it's maybe a
22 little bit more obvious how health care --

1 MS. MAINO-FIKE: Yes. Okay.

2 MEMBER BIALEK: Yes. Yes.

3 MEMBER PESTRONK: In the framework
4 that you were helping us develop, that's a
5 second of the strategic priorities which have
6 to do with refining the guidance and the
7 definitions. Really refining so what's the
8 project about right now? What's this work at
9 NQF all about right now?

10 And so we just did a deep dive
11 into one strategic priority that were listed
12 under some of the other ones, a number of
13 ideas. What someone has to decide is which of
14 the strategic priorities is going to be a
15 focus first or is there some sequence in which
16 -- some order of prioritization?

17 MS. MAINO-FIKE: Right.

18 MEMBER PESTRONK: And then what
19 are their resources within NRQ to do, because
20 we're not going to be able to do that work.
21 We've all got full time jobs somewhere else.

22 MS. MAINO-FIKE: Right. But if we

1 take these as the strategic priorities that
2 you're talking about, then -- and Helen, check
3 me if I'm wrong here, but we're gathering this
4 information, then there are some choice points
5 for NQF to look at. Do we want to pursue some
6 of these things? If so, how and in what
7 order?

8 MEMBER PESTRONK: So the five, as
9 an example, just the way that I was keeping my
10 own notes about this. The five, and these are
11 in no particular order but they're --

12 MS. MAINO-FIKE: Excuse me one
13 second.

14 MEMBER PESTRONK: Yes.

15 MS. MAINO-FIKE: I just want to
16 make sure that you're going to be recording
17 the five, the five items that --

18 COURT REPORTER: I'm recording
19 everything.

20 MEMBER PESTRONK: So identifying
21 other measures in use or other partners,
22 that's the one we just got through talking

1 about.

2 A second potential priority is
3 refining the guidance and the definitions for
4 the project and for NQF. And under that just
5 revising the work sheet or giving examples,
6 providing technical assistance. Those are,
7 you know one level down from refining the
8 guidance and the definitions.

9 A third potential area is reducing
10 the burden for people that have to submit. So
11 increasing time or finding funding to support
12 developers, or making it fun for developers to
13 submit would be things that could be done
14 under there.

15 A fourth is describing the NQF
16 value proposition so that people understand
17 the potential users and uses, as that's the
18 way it was described earlier.

19 And a fifth is simply raising the
20 brand awareness of NQF, and that has to do
21 with outreach into specific places and to help
22 people understand what NQF is all about.

1 So if those are five different
2 areas of work and we've got examples, we've
3 described ways in which each of those could be
4 flushed out at the next level. Now somebody
5 has to decide what's the best one to focus on
6 first, or the best ones to focus on first and
7 what kinds of resources are there available to
8 get that kind of work of done? What would it
9 take to get that work done?

10 MS. MAINO-FIKE: Okay.

11 MEMBER PESTRONK: That's the way
12 my head is processing the conversation.
13 Whether that works for anybody else --

14 MS. MAINO-FIKE: Right.

15 MEMBER PESTRONK: -- I don't know.

16 MS. MAINO-FIKE: No. That makes
17 perfect sense in that the five strategic areas
18 that you're describing are sort of the scale
19 or the bones of the fish diagram and some of
20 the particulars off of them. As you said, we
21 kind of did a deep dive into who's out there
22 doing an environmental analysis for partners.

1 Are there any other things or
2 strategic areas that we would do differently
3 other than those five? Can anybody think of
4 anything else? Helen?

5 DR. BURSTIN: I just would love to
6 have this group actually help us talk through
7 the value proposition. I mean, we keep saying
8 we need one, but I think it would be actually
9 really helpful if we have the time to actually
10 walk through what would make other folks want
11 to bring those measures forward to NQF and/or
12 what would make developers like NCQA
13 potentially think about a different approach
14 to bringing measures that are closer to what
15 you actually want.

16 MS. MAINO-FIKE: Yes.

17 DR. BURSTIN: And need.

18 MS. MAINO-FIKE: Well I see being
19 able to carve out the time. We were planning
20 on a working lunch anyway. So maybe we can
21 take a deep dive, if you will, into
22 articulating that value proposition.

1 MEMBER PESTRONK: Can I make a
2 suggestion, Helen, on that point? Who here at
3 NQF now could characterize the value
4 proposition for your current customers, the
5 people who are making use of what you
6 typically generate? Because rather than
7 trying to develop something de novo, couldn't
8 we see what you think the value proposition is
9 now for them and adapt it?

10 DR. BURSTIN: And I can do that
11 easily and I'm happy to do that after we'll
12 get food. And perhaps if you want to talk
13 about that if that's useful. It's just not
14 clear to me. I understand how it works in
15 sort of the spheres that Sarah and I live in
16 to a certain extent, and Amir. I'm not sure
17 I understand how that translates to a public
18 health agency and would they see the value if
19 their measures don't need to be endorsed to be
20 picked up for accreditation.

21 MS. MAINO-FIKE: Yes.

22 DR. BURSTIN: If their measures

1 don't need to be endorsed to be picked for
2 whatever purposes we're discussing.

3 I mean, the harmonization piece I
4 got, the linked piece I get. But it's the
5 concentric circles out that is harder for me.

6 CO-CHAIR JARRIS: How well do you
7 understand how NCQA and other groups that
8 already submit measures to you would value
9 this, or do they value it? NCQA came
10 yesterday with a measure of did a doctor
11 assess a BMI or provider assess a BMI. They
12 could have withheld plan data, come with a
13 measure that says what is the average BMI in
14 the population served by this insurer? Very
15 different. Or what is the rate of obesity in
16 the population insured? They didn't go there.
17 They still stuck with a one-on-one clinical
18 approach. So why didn't they go there? They
19 really could, it'd be a leader here, but are
20 they working on it?

21 DR. BURSTIN: I think they're
22 working on it. I mean, again this

1 unfortunate. The issues of resources. I
2 mean, they're working on it, they're getting
3 funding to do new Medicaid measures that do
4 some of that. These are traditional HEDIS
5 measures, Sarah can probably speak to this
6 better than anybody here having worked on
7 them, where they need to have a set of
8 measures they can use to accredit health plans
9 which at least traditional have been about the
10 patient interaction.

11 Do you want to speak to that,
12 Sarah, more than me?

13 MEMBER SAMPSEL: Yes. I mean, some
14 ways you know to answer the question why did
15 NCQA bring what they brought, it's what they
16 have. You know, so we also had this
17 discussion a couple of times yesterday is
18 that, you know this group is making a
19 distinction between clinical measures and
20 population health measures, and we probably
21 should have looked at those measures in phase
22 I. But they were held, you know and we were

1 told last fall that they were going to be
2 held, the BMI measures because we thought we'd
3 get more population health type measures.

4 You know, I don't think NCQA has
5 historically pushed nor has, you know AMA
6 PCPI, nor has CMS to look at broader
7 categories that aren't visit-based measures.
8 You know, it's just something that their
9 audience is, you know health plans. You know,
10 they're looking at what are large employers
11 requiring of health plans. And they also have
12 to develop measures based on the data
13 available through health plan data.

14 But to broaden that yes, you're
15 going to start seeing some very different
16 measures come out of NCQA. They just had a
17 call for measures that closed Tuesday for that
18 Medicaid project. So looking for the core set
19 of child paternal health measures. But in all
20 honesty, very similar to a HEDIS measure
21 except adapted for a Medicaid population.

22 They just haven't been pushed.

1 MS. MAINO-FIKE: So let's do this
2 -- sorry. Ron?

3 MEMBER BIALEK: Is anybody pushing
4 when it comes to the accountable care
5 organizations? You'd think that there would
6 be a different set of measures needed when you
7 get -- because that's not all individual
8 patient focused.

9 MEMBER SAMPSEL: Yes. So, and I
10 don't know how much Kaiser is doing any of
11 this. But when you look at our portfolio of
12 metrics whether it's ACO or some of the stuff
13 that we're doing to incentivize providers by
14 paying them for quality, we're still using
15 HEDIS indicators and adapting them for use in
16 those models. But that's part of the value
17 part, it comes back to the value proposition.
18 As a plan, we don't like to create our own
19 measures. It's a lot of work, it's time
20 intensive. So then we come back to, okay,
21 what does NQF have out there that they
22 endorsed? You know, it's a vicious --

1 CO-CHAIR JARRIS: Part of this is
2 that the market isn't driving what we'd like
3 it to drive. And so one of the strategic
4 questions is how do you change the market?

5 I mean, when we were a health
6 plan, GE came to us and said "You get
7 accreditation, we're talking our business away
8 from you." All of a sudden we had a reason to
9 do it, and we did it. And then, you know they
10 would come and basically say "I want you to
11 jump," and it would be "How high?" So, who is
12 saying jump?

13 Because I do think an employer,
14 like as sophisticated as GE was when they were
15 looking at combining -- they were just looking
16 at productivity and absenteeism completely and
17 wanted to combine their health care with their
18 disability, with their worker's compensation.
19 They were hugely sophisticated. So wouldn't
20 GE get the fact that we want you to look at
21 our entire insured population to ensure
22 they're healthy? Not just that the doctor

1 gave the shot at the visit.

2 MEMBER SAMPSEL: And I would say
3 most plans are doing that for large groups
4 like that. You know, for the national
5 accounts we're able to take data from them or
6 they're taking data from us. we're all sharing
7 data and doing that. But, you know who's
8 wagging the tail right now is CMS with the
9 Medicare STARS program.

10 You know, we'd love to see -- and
11 on the Medicaid side it's just still so
12 disorganized in dealing with state by state by
13 state by state requirements of performance
14 guarantees. Do, yes, that's what's driving it
15 still is CMS and large employers.

16 CO-CHAIR JARRIS: So one other
17 stakeholder group to consider, at least going
18 to for ideas, would be like the medical
19 director of GE. They are so phenomenally --
20 the way they think about health was way behind
21 anything we could ever deliver. And the
22 difference is in the private sector -- in the

1 public sector you're going to have to process
2 everything to death, whereas GE could just
3 come and say -- you'd say "Well why do you
4 want us to do that" and they'd say "Because we
5 said so."

6 MEMBER PESTRONK: And that's a
7 piece of the value proposition, Helen, that I
8 think you're trying to create. The value
9 proposition, this is an example from my own
10 practice in a community.

11 I was asked to develop a system
12 which provided primary care to everybody in
13 the community who didn't have access, didn't
14 have insurance or was under insured. And what
15 occurred to me -- and we did the business plan
16 and we did. What occurred to me as I was
17 doing that was if I could have enough -- if I
18 could capture enough people in that health
19 plan, I could influence the practice of
20 medicine in the community.

21 So, the value proposition --
22 that's one statement.

1 The second statement is I assumed,
2 and maybe incorrectly, that the value
3 proposition for me working with you here was
4 that if NQF adopted the right population
5 measures, that the customers who used those
6 measures, Medicare, potentially Medicaid,
7 businesses and others would say "Well, wait a
8 second," you know. "That's actually a better
9 set of measures than the ones that we've been
10 asking the plans and the physicians and other
11 folks to work on."

12 So for people in the practice of
13 public health, the third place of this, my
14 early epiphany in my practice of public health
15 was I walked out of a clinic that we ran in
16 the local community and I looked across the
17 street and there was a school and there was
18 another organization. And I said to myself,
19 you know as the local health official in my
20 community if I can improve health status in
21 the community, I would have done it a long
22 time ago. I needed a range of other partners

1 to get that done.

2 So the third piece of this is if
3 you've got that leverage at NQF to make those
4 things happen that I just described and you
5 can say to the public health practice partners
6 we have that leverage if you can help us get
7 the right indicators, your job of improving
8 health in the community will be much easier
9 because we are your partner. You didn't know
10 that, but we are. And here's what we can do
11 for you, which is always a sales job, it's
12 always the value proposition. It's not --
13 you're telling somebody else what you can do
14 for them. That's the real value proposition
15 that attracts the people in public health in
16 who are on the cutting edge of trying to get
17 something done in their community other than
18 the direct delivery of services which they're
19 no longer getting funded to do.

20 MS. MAINO-FIKE: And I think
21 that's a perfect spot for us to take a break.
22 Lunch is here I'm told. Okay. Okay.

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We are planning to have a working lunch, but let's take until quarter after 12:00 at least to just get ourselves some lunch, take care of whatever our needs are and then we can reconvene.

All right. Thanks.

(Whereupon, the above-entitled matter went off the record at 12:07 p.m. and resumed at 12:52 p.m.)

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A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

12:53 p.m.

MS. MAINO-FIKE: All right.

Everybody, let's reconvene. I will not take offense if you're finishing up your lunch.

What we did while we were on break is to go ahead and capture on the screen here those five fish bones, if you will, or five strategic activities in order to improve our results when whether we resubmit the call for measures or put out any call for measures what we would want to do differently.

First of all, I'd like to take and make sure that this captures what we were saying appropriately. Then what we're going to do: We took a deep dive into No. 1 identifying our partners and who those folks could be. We had a conversation, I'm not quite sure we're done with that conversation around NQF's value proposition. So we're going to finish that up. And then what we can do once we have agreement on those five key

1 things to moving forward is to have some
2 discussion about next steps in each of these
3 five areas.

4 So I think what Robert summarized
5 very nicely that was on the flip charts that
6 nobody could see were the five strategies that
7 we want to use to improving our data call
8 response.

9 So what we said it's important
10 that we identify partners:

11 We want to solicit targeted
12 developers;

13 We want to establish some sort of
14 community practice or key partners and do some
15 collaborative analysis, and;

16 Who's out there that might have
17 information? And we said we categorize them
18 under academic, funding, practice or others.
19 And we have some initial examples of some of
20 those organizations.

21 And then we also said we needed to
22 refine guidance, and that includes:

1 Revising the work sheet, including
2 some examples of completed measures;

3 Providing some technical support,
4 and;

5 Providing some training or
6 education for developers as well.

7 We also said we wanted to reduce
8 the burden to submit for our developers. And
9 that might mean increasing the length of time
10 they have to meet their deadline.

11 And utilize this two stage process
12 to introduce the measure concepts. And so
13 that might make it easier for them.

14 We also said we needed to describe
15 NQF's value proposition if we reach out to a
16 broader constituency, and how would we do
17 that? Explaining to people that harmonizing
18 standards from the health care delivery
19 results in improved surveillance or assessment
20 of public health.

21 We also said establish measure
22 developers from clinical care and public

1 health, bring them together in some kind of
2 forum to develop draft measures that could be
3 used in both domains. That had to do with,
4 you know where is that sweet spot where both
5 domains overlap and can we get some measure
6 developers from each of those areas to kind of
7 put their heads together and come up with some
8 sample measures.

9 And then we also said another
10 thing we needed to do was raise the brand
11 awareness of NQF, meaning there raise NQF's
12 recognition, if you will, out there with a
13 broader constituency base and what role they
14 may be able to play in standard of measures
15 beyond just the clinical arena.

16 Does that capture what we had
17 discussed earlier before the lunch break?

18 CO-CHAIR JARRIS: Could I offer
19 some modifications? Kristin, do you mind
20 going down?

21 So I think the community practice
22 and partners for me I consider that under part

1 of the cluster of technical assistance,
2 training and education. To actually put
3 together a group of people who work on these
4 things who can inform and educate people and
5 support each other. So, I was just dropping
6 that down.

7 And then making collaborative
8 analysis, which is B. That is an activity in
9 and of itself as opposed to being under
10 community practice. So I'd drop that
11 community practice down as an E, perhaps, or
12 something or other under two.

13 MS. MAINO-FIKE: Under Refining
14 Guidance?

15 CO-CHAIR JARRIS: Yes, it could be
16 under that or Reduce the Burden to Submit,
17 either one of those really.

18 And the issue of brand awareness
19 of NQF, I do think that's very important but--

20 MS. MAINO-FIKE: It's not a
21 Strategic Objective?

22 CO-CHAIR JARRIS: It's not the

1 responsibility of this group. Now we might
2 have a responsibility to be representatives
3 about talking about NQF's relevance to the
4 public health community if we define that
5 value proposition. But the branding of NQF is
6 NQF's issue.

7 And I also by brand, it's not a
8 let's go tell everyone NQF is important about
9 this. To me that's a much more complex
10 construct which includes NQF looking at who it
11 is and deciding whether this is part of what
12 NQF is, and if it is, restructuring itself to
13 do this kind of business and that is an
14 organizational development process for NQF.
15 A brand is what comes to people's mind when
16 they think of NQF; that's pretty far
17 downstream.

18 MEMBER STOTO: I think really this
19 is related to the value proposition thing.

20 CO-CHAIR JARRIS: Yes.

21 MEMBER STOTO: And it's whatever
22 NQF's brand is is making the public health

1 community understand how that might be
2 relevant to them.

3 CO-CHAIR JARRIS: Yes.

4 MS. MAINO-FIKE: So, yes. Okay.
5 That makes sense to me. Raising the
6 awareness.

7 And I'll come back to you, Robert.
8 Was there something around the fifth strategic
9 objective that we did not capture?

10 MEMBER PESTRONK: You mean why I
11 had it as a separate priority?

12 MS. MAINO-FIKE: Yes, or if you're
13 comfortable. We want to make sure everybody's
14 comfortable with the way we're looking at
15 something. So, are you comfortable with the
16 way it is now? Is there something else that
17 you would see going under the fifth strategic
18 objective?

19 MEMBER PESTRONK: Glad you didn't
20 capture the "um."

21 I think now it's a question of
22 sort of lumping and splitting.

1 CO-CHAIR JARRIS: Yes.

2 MEMBER PESTRONK: So, I'm
3 comfortable.

4 MS. MAINO-FIKE: Okay. Fine.

5 MEMBER PESTRONK: The reason why I
6 included raising brand awareness as a separate
7 issue was because I wasn't thinking
8 specifically about the work of this particular
9 group, and I was thinking about us as helping
10 the population health staff at NQF frame their
11 presentation to the NQF Board, for example,
12 and that what we were doing here was serving,
13 if you will, as a Board of Directors
14 appropriately or not for Helen and her staff
15 as they're trying to think through their role
16 within NQF. And so that was why I had it as
17 a separate strategic priority, but I mean I
18 don't care.

19 CO-CHAIR JARRIS: I think there's
20 something there, but I think I kind of feel
21 like the blind man feeling the elephant
22 because is there a populational staff in NQF?

1 We have NPP, National Priorities Partnership
2 which has staff working on this. We have this
3 group. And then I don't know where the MAP
4 process exists -- I don't know a lot about it
5 in NQF, the Measure Applications Partnership.
6 Because they are starting, apparently, to look
7 at population health in something that I just
8 learned about today. So there's all this
9 stuff going on. I have no idea whether there
10 is a -- well, we have not been introduced to
11 the notion about whether there is a strategic
12 vision and strategic process NQF is doing or
13 whether these are random things going on. And
14 I feel like we're working for an intelligence
15 agency where we don't know what the other
16 cells are doing. But what's going on? How do
17 we fit together?

18 MEMBER PESTRONK: Yes, I don't
19 know any of that and so I assume that there is
20 a population health staff and we've been
21 working with them.

22 DR. BURSTIN: I mean, in general

1 there have been a set of activities that are
2 actually quite connected. I mean, Wendy
3 Vernon was here the entire morning listening
4 from NPP. National Priorities Partnership has
5 been staffing the work group that you and
6 Peter have been working on.

7 The MAP is just sort of in its
8 preconceptual phase of thinking about creating
9 these families of measures, this idea of sort
10 of cascading up and down. And one of the
11 topics on the list for the future is
12 population health as being something
13 considered.

14 There's nothing else happening at
15 the moment. These activities are all about
16 how do we sort of move this field forward.
17 Our role in this are there measures out there
18 to bring forward? NPP is setting sort of the
19 broader vision and the MAP is trying to work
20 on alignment across the public and private
21 sectors. So there are different pieces of the
22 puzzle, but I think the issue really is I

1 think particularly because we're guided by the
2 National Quality Strategy. That's how we kind
3 of do our work. They could not have made it
4 more clear that population health is front and
5 center and a high priority. So, it is a higher
6 priority for NQF. I think the only issue is
7 how do we operationalize that I think is the
8 issue that's still not completely clear.

9 MEMBER SPANGLER: Helen, a quick
10 question. Did someone replace Bonnie's
11 position or that position was eliminated?

12 DR. BURSTIN: No, we have not
13 brought in content specific people. I mean,
14 Robyn does her work on disparities, has done
15 a lot of work in this field. And Elisa has
16 been doing this work for us assigned to this
17 space. But no.

18 MEMBER PESTRONK: So in the
19 context of the conversation this morning could
20 you have asked the other -- in the call for
21 population health measures could other
22 sections of NQF itself have responded to those

1 call for measures because there are this other
2 work going within NQF or --

3 DR. BURSTIN: NQF never develops
4 measures. That's a hard line for us. So no
5 one else within NQF is developing measures.
6 And, in fact, we did have the NPP folks weigh
7 in on our call for measures and were actually
8 quite helpful. But, no, there is no measure
9 development within NQF.

10 MEMBER PESTRONK: Is there a set
11 of customers or partners for the other
12 population health work at NQF --

13 DR. BURSTIN: No.

14 MEMBER PESTRONK: -- that could
15 have extended outreach?

16 DR. BURSTIN: Yes, and we work
17 closely with Karen and Wendy to see who those
18 people were. Yes, and we did.

19 MEMBER PESTRONK: And you work
20 closely with them? Okay.

21 DR. BURSTIN: Yes. And the MAP
22 stuff is really pre-contemplative, so there's

1 nobody to work with there yet.

2 MEMBER PESTRONK: I had in mind
3 under the raise brand awareness as a fifth
4 area outreach into specific places that might
5 be helpful or might be able to suggest
6 measures since that's where we were focused.

7 MS. MAINO-FIKE: I noticed, Matt,
8 you have a comment.

9 MEMBER STIEFEL: 4b, I was
10 originally thinking that not so much as an
11 activity describing NQF's value proposition,
12 but actually jump-starting the measure
13 development process or creating a use case or
14 being a very important first step. That may
15 push NQF up against that bright line of
16 measure development, and one I'm not sure how
17 you navigate. But if it's a convener role of
18 measure developers, then maybe that's all
19 right. But I see that as fundamentally
20 different then describing the value
21 proposition. It's jump-starting the
22 population health measure development process

1 by doing it, or at least convening this group
2 of stakeholders and in so doing I think
3 demonstrating the value, the mutual benefit.

4 And I hope we get to actually do
5 what you asked, Helen, is to talk a little
6 more about the value proposition before we're
7 done.

8 MS. MAINO-FIKE: Yes. Yes. That is
9 definitely the next step. What I wanted to do
10 was get some agreement that what we have here
11 kind of captures the key strategies, if you
12 will.

13 So I'm going to say, you know
14 perhaps -- I hear what you're saying. It's
15 not part of NQF's value proposition. It might
16 be more around NQF's potential role in
17 bringing disparate parties together or
18 convening different parties to jump-start the
19 measure process. Would you see that --

20 MEMBER STOTO: I think it very
21 much is the value proposition, but it's not
22 describing it. It's creating it.

1 MS. MAINO-FIKE: Right. Right.

2 MEMBER STOTO: And in this new
3 realm that NQF has not done that much business
4 in.

5 MS. MAINO-FIKE: And so maybe we
6 could put it under value proposition but just
7 in terms of what is --

8 MEMBER STOTO: But the other thing
9 I'd like to add about that is that another
10 important step there is this identifying the
11 potential users and uses of NQF-endorsed
12 measures in this space. Because I think that
13 helps to figure out what the value proposition
14 is as well.

15 MS. MAINO-FIKE: Right. So C
16 might be a list of potential users and uses?
17 Would you see that as C under the value
18 proposition, a list of potential uses and
19 users?

20 CO-CHAIR JARRIS: How much is the
21 issue here that value proposition has to be
22 created for NQF endorsement, which is what NQF

1 does, versus a value proposition has to be
2 created for population health measures?
3 Because NQF is like the last step in this
4 where they endorse a measure that someone else
5 has developed. But if we're really talking
6 about this being developmental all the way
7 from we're having conceptual problems to
8 practical problems, to who would use it
9 anyway, to why would anyone want one that's
10 way before an endorsement process. So I'm
11 wondering, and part of the question is who
12 should be playing in this field either as a
13 partner of NQF or rather in advance of NQF?
14 Because I mean a lot of this smells like if
15 anyone has an extra million bucks an IOM type
16 study.

17 MEMBER STOTO: So that's why I
18 wanted to put in identify the users and uses
19 because that really creates the value
20 proposition, or at least helps to clarify the
21 value proposition with respect to population
22 health measures. And then the question is if

1 we're going to have those, what can NQF add to
2 that?

3 MS. MAINO-FIKE: Right.

4 MEMBER STIEFEL: I mean, it
5 depends on your diagnosis of the problem.

6 I don't know that we have a
7 significant shortage of measures. We maybe
8 have an over abundance of measures. I think
9 there's probably a shortage on the very top of
10 HealthyPeople healthy life expectancy where we
11 don't do that as well as other countries. But
12 below that, there are busloads, truckloads of
13 thousands and thousands, and so that the value
14 proposition may well be in the endorsement as
15 opposed to the development, and especially if
16 that endorsement bridges this gap that we've
17 talked about between clinical and community by
18 having a consistent set of measures used for
19 performance improvement that also can be used
20 for assessment.

21 MS. MAINO-FIKE: Right. I think
22 you're bringing up a good point which is, you

1 know kind of a discussion of what comes first,
2 the chicken or the egg. Does NQF want to look
3 at -- in their efforts to look at measures, do
4 they want to expand their role to include
5 creating forums to convene groups so there's
6 a choice point about a role there that is good
7 to highlight, it's just a choice point. So
8 NQF could play a role.

9 In an area where it's a new area
10 where does the public and the one-on-one
11 clinical areas oversect to assess health?
12 That's kind of a new area. We've got a lot of
13 stuff going on, but no standardization. So,
14 NQF has a choice point to broaden their role
15 a little bit and see if they want to be or
16 take on convening so that then they're further
17 along in standardization and measures and
18 would be able to then fall back into their
19 normal role of endorsement.

20 So, yes, Ron?

21 MEMBER BIALEK: I'm also thinking
22 that any of the elements within the value

1 proposition are choice points for NQF in that
2 we can sit around and come up what we think
3 the value proposition is. It really is the
4 Board that needs to say we agree or disagree.

5 MS. MAINO-FIKE: Correct.

6 MEMBER BIALEK: You know, so
7 before one would go out and tell folks this is
8 the value proposition, the Board needs to say
9 we agree --

10 MS. MAINO-FIKE: Right.

11 MEMBER BIALEK: -- or here's how
12 we modify it.

13 MS. MAINO-FIKE: Right. And
14 that's a really good point because one of the
15 benefits of getting a group like this together
16 is to come up with thorough recommendations
17 that, you know Ron to your point, then the
18 Board has to make some choices regarding what
19 they want to pursue, what they agree with,
20 what they don't agree with. So the value of
21 this group coming together -- one of the
22 values of this group coming together is to

1 give them some ideas. The benefit of your
2 opinions, and that's what I think this is.

3 If we want to move forward, you
4 know here are some ways that we can do it.

5 So if we're okay with the way we
6 sort of organized, I don't want to over assess
7 how we've organized each of these steps and
8 not get to taking some action on them. So if
9 we're okay, if you're comfortable with how
10 things are reflected and organized here in
11 these four areas, then the next thing that we
12 want to do is circle that -- yes, Helen?

13 DR. BURSTIN: I'm still
14 struggling, and I understand Paul's point
15 about the value proposition and the branding
16 being about NQF. But I'm struggling about
17 whether -- and I think this is a question for
18 the highest levels of this group and NQF, and
19 whatever. How far out in those concentric
20 circles do we go?

21 I have no doubt that it is
22 directly relevant when a measure clearly has

1 some linkage back and influences what happens
2 in a health plan, in a health care system, et
3 cetera. For example, we endorsed the measure
4 last year that looked at number of days kids
5 missed from school. No brainer. Incredibly
6 useful. I think it's a population health
7 measure. I think you'd agree. But it's
8 incredibly useful. You can see how the health
9 system or Kaiser would love to have a
10 standardize way to track something like that
11 for their kids with asthma in their health
12 system.

13 I think the question is how far
14 out does this group think is logical for NQF
15 to go. Because I think we have to bring a set
16 of questions like that to the Board, which we
17 haven't yet.

18 CO-CHAIR JARRIS: I think it's a
19 developmental process and it'll change over
20 time. But the clinical world will go out so
21 far, there will be some overlap with public
22 health which will go out further. But we have

1 this debate in public health all the time
2 also. You know, should we be having somebody
3 full time sitting in on the Transportation
4 Commission meetings?

5 So, I think public health will go
6 further than NQF can go. And so when we
7 developed those three parts in the NPP the
8 reason we plugged in there at clinical
9 provided services was just to do that bridge
10 to the clinical world to say okay, that can be
11 measured at a patient population level, so
12 we'll call that population health. At least
13 some of us choked that down realizing it was
14 a developmental thing we had to do to bridge
15 to clinical medicine.

16 MEMBER PESTRONK: It is just to
17 some extent another one of those strategic
18 choices. Because what Neil told us this
19 morning in his presentation was there are
20 other organizations and groups going out to
21 the other space already. And so if they're out
22 there, something's going to happen out there

1 where people are going to turn to them if
2 they're successful when they're looking for
3 the measures to be used. And the question for
4 NQF is to what extent is their business model
5 potentially -- I mean, in the worse case in
6 jeopardy because the world moves to find the
7 measures that NQF has heretofore offered as
8 insufficient and they turn somewhere else for
9 them.

10 CO-CHAIR JARRIS: There are
11 already, you know major players in the
12 Catholic Health Association that talks about
13 "community building," which is safe housing,
14 job creation, things like that. So there's
15 some who get this. But I mean I think we just
16 have to move at a pace and my sense is that
17 NQF will be a relatively conservative pace,
18 which is fine.

19 MS. MAINO-FIKE: I wonder if that
20 is perhaps a fifth strategic area, that being
21 describing the boundaries, those concentric
22 cycles that you were talking about, Helen.

1 What are the boundaries or the circles that
2 this group and NQF wants to play within, given
3 that it's this point in time? Not, Paul, as
4 you said you know it's an evolutionary
5 process. They may be expanded, but to put sort
6 of a stake in the ground. I wonder if that's
7 one of the strategic objectives that needs to
8 be decided?

9 Matt?

10 MEMBER STIEFEL: So I think the
11 stake in the ground is the intersection. I
12 mean, that requires more thinking about what
13 that intersection is.

14 Thinking about income. It's hard
15 to imagine NQF would ever be endorsing a high
16 school graduation rate measure. But that
17 caused me to think about the community health
18 needs assessment and it's an interesting,
19 maybe use case, because it sits at this
20 intersection. It's a requirement of hospitals
21 to play in the public health arena.

22 Unfortunately, I think hospitals

1 are looking at that as what are the
2 traditional public health measures and
3 actually even KP is looking at that as well,
4 high school graduation rates and availability
5 of parks. But that could be an opportunity to
6 think about what can the health care delivery
7 system contribute to public health in this
8 Community Health Needs Assessment. A
9 reframing. And that may be a very significant
10 opportunity. And so you could think of sets
11 of measures. It's a different approach that
12 the Community Health Needs Assessment would be
13 something that is endorsed or a whole health
14 risk assessment that has lots of measures
15 within it for standardization.

16 CO-CHAIR JARRIS: I agree. I
17 think that the place to emphasize initially is
18 that interface. And I think that HIV measure
19 actually did that quite well. If there are
20 specific measures that can be used for
21 community health assessments by hospitals and
22 community health improvement plans, that would

1 be helpful. But I wouldn't set a line to say
2 we don't go beyond here. I would let the
3 methodology do that for us because if some
4 really smart person figured out how to
5 demonstrate a clear evidence link between high
6 school graduation and health that people could
7 say "Wow. They nailed it and they met the
8 criteria." Then let's go for it and take it
9 as opposed to say dismissing it out of hand.
10 Over time, hopefully, people will get smart
11 enough and the evidence-base will develop so
12 we can tie those things in.

13 MS. MAINO-FIKE: Okay.

14 MEMBER STOTO: I would just like
15 to support Matt's point as a starting point.
16 Because I think the critical thing there is
17 that the hospitals already know about NQF and
18 they're about the only ones in this space that
19 we're talking about -- well, maybe not the
20 only ones. But they're the ones that know NQF
21 the best.

22 MS. MAINO-FIKE: Yes. Yes. So

1 maybe the fifth objective or category might be
2 initial areas or opportunities to move into
3 the public health space?

4 MEMBER STOTO: It's really what I
5 had in mind when I said identify potential
6 users and uses. I mean, I think the Community
7 Health Needs Assessment IRS requirements or so
8 on are the primary one to start with in that
9 area.

10 MS. MAINO-FIKE: Yes. Yes.

11 MEMBER STOTO: It's not something
12 that's not already on the list.

13 DR. BURSTIN: Or just a series of
14 use cases, which I really think is what we're
15 kind of listing out, which I think is very
16 helpful.

17 Also, the Office of the National
18 Coordinator is developing a series, I'm told,
19 of more population health -- or interested in
20 developing a series of more population health
21 measures for meaningful use stage 3 for 2015.
22 We just met with them this week. So again,

1 they're thinking very prospectively about what
2 they could do differently. So we can
3 certainly explore those options, too.

4 MEMBER STIEFEL: Another one is
5 the Medicare HRA that's required now. That's
6 a set -- again, it's a set of measures, many
7 of which are very important population health
8 measures.

9 MS. MAINO-FIKE: So I think what
10 we're starting to get into is where are some
11 low-hanging fruit or initial first steps that
12 NQF and this group should move forward on,
13 take as first steps.

14 So I'd appreciate if you wouldn't
15 mind recording just maybe exactly that. Maybe
16 we don't have a fifth category. It's just, you
17 know proposed next steps could include and
18 some of these projects are good examples.

19 MEMBER PESTRONK: I actually like
20 thinking about it as a fifth category because
21 it's sort of a first decision. It's the first
22 decision to make about then how you go about

1 defining the value proposition because you are
2 forced to think about who are your initial
3 customers for the products that will come out
4 of NQF. And if in fact it's in the sweet spot
5 that Matt has described, then the customer,
6 the traditional customers which are still good
7 customers for NQF are the governmental
8 customers out of HHS who have turned to NQF
9 for these population health measures. And it
10 could be expanded, the value proposition could
11 be expanded to include the state governmental
12 customer because they are Medicaid -- and they
13 are Medicaid on a practical basis and those
14 state directors could use these metrics within
15 their own states.

16 And then I was thinking about the
17 other governmental customer, before we broke
18 for lunch. as the local customer and the value
19 proposition there that I was trying to
20 describe was NQF and its metrics are partners
21 for those local health department director
22 because the metrics that get adopted and

1 promoted by NQF influence the practice and
2 operationalization of the health care system
3 in each of those director's communities. And
4 therefore, NQF becomes a partner to leverage
5 change that the local health department can't
6 leverage or the director can't leverage on his
7 or her own, which is exactly where people are
8 trying to push the local health department
9 directors and the state health department
10 directors to not think that they have the
11 capacity on their own to create healthier
12 communities, but in a time of scarce resources
13 to leverage the resources that exist elsewhere
14 to make that happen.

15 And so in my colleague Paul
16 Jarris' jargon what NQF is actually doing is
17 trying to leverage through its work the
18 enterprise of the governmental public health
19 system, to leverage its work in both
20 traditional and new ways.

21 CO-CHAIR JARRIS: The Community
22 Health Assessments, I think that's a very rich

1 area to look at because we have, as you said,
2 the public health accreditation requiring all
3 state and local health departments, and tribal
4 and territorial health departments do
5 Community Health Assessments, Community Health
6 Improvement plan. Nonprofit hospitals have to
7 do that. Well, what part of the metrics
8 they're going to use, and wouldn't it be
9 useful to have standardized metrics so when
10 that hospital who covers three communities in
11 this state develops assessments of population
12 health, it's the same set of measures that the
13 three local health departments and the state
14 health department engaged with that hospital
15 are measuring. That would be a very powerful
16 set of tools.

17 MEMBER STIEFEL: And it's evolving
18 not coordinated, not harmonized.

19 MS. MAINO-FIKE: Right.

20 MEMBER STIEFEL: So the community
21 hospitals in the same geographic area are
22 developing their own Community Health Needs

1 Assessment as is the public health entity.

2 So they're like three or four or five
3 different health assessments in the same
4 community.

5 MEMBER PESTRONK: Yes. And you've
6 got new payment methodologies which are meant
7 to address populations rather than
8 individuals. And so those payers need
9 measures to determine whether the needle has
10 moved from one place to another as a result of
11 what they're funding. And that's a federal,
12 state and local opportunity also.

13 CO-CHAIR JARRIS: And the 990 form
14 on an annual basis, a nonprofit hospital has
15 to report on their Community Health
16 Assessment, which priorities they're
17 addressing and which they are not. And if
18 not, why not.

19 So again, let's have some
20 standardized way of looking at this, otherwise
21 it's just going to be meaningless what's
22 coming out.

1 MS. MAINO-FIKE: I want to capture
2 some of this.

3 I'm thinking some of this
4 conversation should go under that value
5 proposition or value equation. I'm also
6 thinking that just so you have something
7 concrete to leave this meeting with, that
8 maybe number five here does go back to
9 identifying potential uses and users. And then
10 we specifically identify where some of those
11 areas are.

12 We already talked about the
13 community hospitals and leveraging what
14 they're doing.

15 So if we could do that reflected
16 here, that would be great. And then let's --
17 I know, Matt, you mentioned this. The other
18 thing I'd like to circle back to, people have
19 mentioned this a few times, is coming back to
20 that value equation. We don't need to come up
21 with one value equation, but if we can
22 summarize what that value equation might be,

1 I think that would make good use of the brain
2 power in this room and help NQF look at making
3 their choice points about how they choose to
4 take action going forward.

5 So, let's look at that value
6 proposition. We have A, B -- I think we
7 should move this to number 5. What are some
8 further ideas about what the value equation
9 was?

10 I know we broke for our lunch
11 when, Robert, you were kind of summarizing
12 what you thought NQF's leverage was.

13 CO-CHAIR JARRIS: One thing we
14 talked about yesterday, which I think would be
15 very helpful, is there are so many surveys out
16 there and data collection tools that all
17 define what they're collecting differently.

18 MS. MAINO-FIKE: Yes.

19 CO-CHAIR JARRIS: And that I think
20 would be tremendously valuable if all those
21 different surveys used the same measure so
22 that there's comparability. You could say,

1 okay, YRBS goes up to age 18, BRFSS starts 18
2 to 64. So guess what? We now know what
3 happens between this age range as opposed to
4 there's a break in your knowledge because it's
5 a different survey question.

6 MS. MAINO-FIKE: So you're seeing
7 that as part of NQF's value equation?

8 CO-CHAIR JARRIS: No, that would
9 be the value of having population measures.
10 You're right. That's not necessarily NQF's --

11 MS. MAINO-FIKE: Right. So maybe
12 we can add that under NQF value equation is
13 one of the things it could do is to play a
14 role in harmonizing the -- could you say that
15 again, Helen?

16 DR. BURSTIN: Harmonizing the
17 national survey system.

18 MEMBER STOTO: And even
19 harmonizing the national surveys among
20 themselves, which --

21 DR. BURSTIN: I was a fed for
22 seven years; that's not an easy proposition.

1 We'll be happy to be a partner in that effort.

2 MEMBER STOTO: Well, I know.

3 Right. And then part of the reason is it's
4 difficult for the feds to do is because
5 everybody's got the same voice. If there were
6 an external group --

7 DR. BURSTIN: Right.

8 MEMBER STOTO: -- that could push
9 it, that that might actually make it easier.

10 MS. MAINO-FIKE: Right. Right. So
11 the value equation is being the outside
12 organization that can get parties together and
13 try to get some standardization.

14 MEMBER PESTRONK: Who's the
15 customer? Because the value proposition is
16 about who the customer is and what one is
17 trying to sell. So, who's the customer here or
18 who are the customers?

19 CO-CHAIR JARRIS: In that case
20 it's the users of the survey. Lots of people
21 use it, so I don't how to get more specific.
22 But wouldn't it be nice if the information

1 from those surveys was clearer or more
2 consistent and had more utility? And that
3 could be public health agencies. It could be
4 clinical folks if they're trying to --
5 because, you know we have this problem of the
6 public population health doing works at the
7 population level largely through surveys and
8 the clinical sector doing work by adding up
9 individuals. And where will the two ever
10 meet?

11 MEMBER STIEFEL: I think the
12 customers are the public health entities that
13 you describe, probably federal, state, local
14 and the health care organizations. And if you
15 think of defining customers that way, I think
16 that there's value to each: The value to the
17 public health entities is having this rich
18 vein of data from the clinical care delivery
19 system. And the value to the clinical care
20 delivery system is that with harmonized
21 measures you've got benchmarks to measure your
22 performance against.

1 MS. MAINO-FIKE: So you're
2 suggesting the customer would be the three
3 different levels of government as well as then
4 the clinical care delivery systems, and that
5 you all could define what the benefits are to
6 each of those customer groups fairly easily?

7 So can we record that?

8 MEMBER STOTO: Another value to
9 the clinical health care system is that at
10 some point the IRS might say well the measure
11 that you use in your needs assessment
12 improvement plans have to meet some standards,
13 and endorsement by NQF could be that standard.

14 MEMBER STIEFEL: Maybe a standard
15 community health needs assessment?

16 MS. MAINO-FIKE: Yes, Sue?

17 MEMBER PICKENS: Would there at
18 some point be value to funding agencies like
19 the United Way that when people apply
20 community-based grants to that say it meets
21 NQF population health measures?

22 MS. MAINO-FIKE: Could that be a

1 possible next step, or would that be something
2 that you would want to include in a value
3 equation?

4 MEMBER STOTO: It's another
5 customer.

6 MS. MAINO-FIKE: It's another
7 customer. Right. So our customers would be
8 the three different governmental levels. If
9 we're just looking at this in a broad way,
10 there'd be the three different governmental
11 levels, there would be the health care
12 delivery systems and could be -- what would
13 you call those? Other organizations that are
14 collecting data? How would you describe them?

15 MEMBER PICKENS: Well, they're
16 actually funding the projects. RWJ would be
17 one that would fund projects in community and
18 population health. They fund the Wisconsin
19 project, and lots of things. So I would call
20 them -- I'd just call them funders.

21 MS. MAINO-FIKE: Project funders?

22 MEMBER PICKENS: Yes.

1 MS. MAINO-FIKE: Okay.

2 MEMBER STIEFEL: And I think it's
3 the three different public health levels as
4 opposed to government. Government sounds too
5 big.

6 MS. MAINO-FIKE: Sounds too Big
7 Brother? So three different -- how would you
8 rephrase that?

9 MEMBER STIEFEL: Levels of public
10 health organizations.

11 MS. MAINO-FIKE: Okay. Yes. So
12 like a federal, state and then a local. Okay.
13 Good.

14 So that helps us a little bit
15 answer the question of who is the customer.

16 Ron, did you want to add to that?

17 MEMBER STIEFEL: One of the
18 dilemmas with the users of the measure being
19 the primary customer is how do we sell to
20 developers? Because as Mike pointed out
21 earlier, there aren't that many developers of
22 the population measures and so we have

1 customers for the measures without necessarily
2 developers.

3 Now, we heard from two: New York
4 City Health Department and California as
5 potential, both customer and developer. But I
6 still think there's that gap out there of why
7 should an organization spend its time, its
8 money developing a measure that ultimately
9 will be used by folks. So one set of
10 customers, yes, are the users of the measures.
11 Another set of customers that I don't really
12 think we've addressed are the developers of
13 the measures.

14 MS. MAINO-FIKE: I understand.

15 Mike?

16 MEMBER STOTO: I think it's an
17 important point. I think that what we think
18 of as developers and what's the other word?
19 Owners or --

20 DR. BURSTIN: Stewards.

21 MEMBER STOTO: Stewards. Might
22 actually have to be rethought in this realm.

1 So when you have something like say the
2 smoking measure that's used on all kinds of
3 federal surveys and could be used in other
4 places, you know what does it really mean to
5 be the developer or the steward of something
6 like that?

7 MS. MAINO-FIKE: So do you think
8 that that would be an action item is to look
9 at how we define these customer groups?

10 MEMBER STOTO: Yes.

11 MS. MAINO-FIKE: Yes. Maybe we
12 can put that under action items.

13 CO-CHAIR JARRIS: You know, I
14 think there's almost an infinite number. You
15 know, every grant has measures you have to
16 meet of performance and the part of what
17 drives people nuts is they come up with
18 measures that they pull out of the air, that
19 then change six months into the grant. You
20 know, so it would actually be nice to have
21 some valid reliable measures to assess your
22 performance against.

1 MS. MAINO-FIKE: Well, isn't that
2 one of the value equations that NQF brings is
3 creating a market, if you will, a desire for
4 an external standard approval where there
5 isn't one now? There is one from a clinical
6 standpoint, but we're saying NQF could be an
7 organization that helps to create that market,
8 that desire in the public health sector. That
9 is a possible benefit to add to the value
10 equation.

11 MEMBER BIALEK: And it's important
12 for those organizations to have these ever
13 changing, incredibly diverse reporting
14 requirements for pretty much the same thing
15 for them to understand the value in having
16 some consistency. I'm not sure they currently
17 do recognize the value in having that.

18 MS. MAINO-FIKE: Okay. So NQF
19 could create some consistency and
20 standardization where there wasn't one, and
21 that's a way to lessen the burden.

22 And, Mike, you had wanted to say

1 something? Never mind.

2 Yes, Kurt?

3 CO-CHAIR STANGE: I really like
4 this idea of focusing on the Community Health
5 Needs Assessment in thinking of the hospitals
6 health care systems as one primary audience.
7 They have this new mandate and then the public
8 health community that's trying to do more with
9 less and realizing they have to convene multi-
10 stakeholder groups. That really is a sweet
11 spot. And if you think of that as the core
12 target audience, you start finding secondary
13 ones that people want to get on board, which
14 would be other government agencies and the
15 business community.

16 And what made me think of that is
17 the measure that Helen mentioned that's
18 already NCQA endorsed that's really about
19 social role function for children and days
20 missed of school. So if you take that to the
21 working population, I mean that's how you
22 engage the business community with days of

1 absenteeism or presentism. So that really gets
2 others involved.

3 And then Paul mentioned anybody
4 who is funding anything wants these outcome
5 measures. I mean, we're making a big pitch in
6 Cleveland to basically all the philanthropic
7 community that they fund all these
8 initiatives, and they under fund the
9 evaluation so they never really know if their
10 money is doing any good. These kind of
11 measures could be something that would be if
12 you made that the baseline that's always being
13 assessed at the neighborhood level and the
14 health care system level in a community, then
15 when they're funding new initiatives and you
16 want to look at what is the impact people
17 being able to go to work, children being able
18 to go to school, health care utilization; if
19 those data are already being collected, then
20 that philanthropic community then doesn't have
21 to put as much of their money into evaluation
22 for every little thing in a way that doesn't

1 matter if they invest in a way that's on a
2 community level.

3 So, I think the core constituency
4 are the people who really have to do this
5 Community Health Needs Assessment because then
6 you start bringing lots of other stakeholders.

7 MS. MAINO-FIKE: Okay. I want to
8 record -- one second. I'm sorry, Matt. Let's
9 record this Community Health Assessment
10 notion. It's been brought up several times as
11 a good maybe first place to start. So maybe we
12 can put that under the proposed next steps.
13 Exploring that, Community Health Assessments,
14 not mandate but action that's already going
15 on.

16 And, Matt?

17 MEMBER STOTO: Well, it's a
18 mandate, it's a law. And then furthermore,
19 it's not just a Community Needs Assessment but
20 it's the improvement plans as well.

21 MS. MAINO-FIKE: Yes.

22 MEMBER STOTO: It's two separate

1 mandates.

2 MS. MAINO-FIKE: Okay.

3 MEMBER STOTO: This requires
4 different kinds of measures.

5 MS. MAINO-FIKE: Matt?

6 MEMBER STIEFEL: Well, to build on
7 that, I think an entire Community Health Needs
8 Assessment would collapse under the weight of
9 the NQF review criteria. Every element of that
10 assessment, that just sounds overwhelming. But
11 perhaps there's some core subset of it. And
12 maybe it's the healthy behaviors, I keep
13 bringing up, that where it's a bite out of it.
14 It's a more tractable subset that NQF could
15 convene, and it could be maybe that group of
16 stakeholders that we talked about of people
17 from public health and people from clinical
18 care delivery measure developers to agree on
19 not the entire thing, but a start, a subset of
20 it.

21 MS. MAINO-FIKE: Yes. That subset
22 could be the healthy behaviors section. And

1 one way to address that which would be to get
2 this group of measure developers, both
3 clinical and public, together to look at that.

4 MEMBER STIEFEL: And the advantage
5 of focusing on that is that is in this
6 intersection sweet spot.

7 MS. MAINO-FIKE: Right.

8 MEMBER STIEFEL: The high school
9 graduation it's harder to make the case.

10 MS. MAINO-FIKE: Right. Well, that
11 goes back to Helen's point of within these
12 concentric circles you know it's easy to make
13 the case that it's a smaller initial
14 concentric circles.

15 Yes, Amir?

16 MEMBER QASEEM: So is it also
17 could be NQF's role be just endorsing of the
18 measures as well, like the performance of the
19 performance measures or evaluation of
20 performance measures. And I don't know is not
21 a conflict of an interplay so that if you
22 endorse the measure, that you should even be

1 evaluating the measures. But I think it's some
2 sort of evaluation in terms of feedback as
3 well whether -- and I don't know if NQF is
4 planning to go that route or not.

5 DR. BURSTIN: We're doing it in a
6 lot of different ways, not as formal as I'd
7 like. Our new search system, the quality
8 positioning system, the quality measures
9 allows you to give feedback on the measures.
10 We've solicited comments every time a measure
11 that's been endorsed is up for maintenance.
12 We try to do an annual assessment of the
13 overall portfolio of what it's being used for.

14 And our Usability Task Force this
15 year changed our usability criterion so all
16 projects beginning in the fall have a much --
17 will need to report on how the measure has
18 proved useful in terms of improvements and
19 also any potential unintended consequences as
20 a result as well. So, we'll start gathering
21 that data as we move forward prospectively.

22 MEMBER QASEEM: In this case I

1 think it's going to be extremely useful
2 because as you've said we've already endorsed
3 some of the measures and I know we're talking
4 about how to make it more attractive to get
5 more measures. But maybe we do need to see
6 what we've already done where it get us.

7 CO-CHAIR JARRIS: I wondered about
8 sort of turning over some rocks such as
9 another place of intersection between the
10 clinical world and the public health world is
11 in vital statistics. And these are hugely
12 unreliable, invalid reams of data being
13 produced that we make national policy
14 decisions on. But it's basically trash.

15 I mean, if you look at what gets
16 into a death record, you're sitting there
17 seeing 30 patients and they bring you a stack
18 like this of records and plop in front of you
19 to say "Your partner's off today, will you
20 fill out this death certificate?" And you're
21 like flipping through this thing saying "Okay.
22 I'll call it diabetes." Well that's not a

1 cause of death, but that's what gets in.

2 So, you know, I don't know if
3 anyone would even want to go there but it's
4 frightening the types of decisions that are
5 made, or who calls in the birth record. It's
6 a clerk who may have some education after high
7 school who is sitting there phoning in or
8 entering into the electronic birth record
9 system the information on the birth.

10 I mean, so I don't know if we want
11 to turn those rocks over, but it is a really
12 frightening -- I mean if you actually look at
13 the quality of the data, it's horrible.

14 DR. BURSTIN: And actually, one of
15 our child health/perinatal measure emerged out
16 of California's effort to do just that, to
17 improve the vital stats data. So they worry
18 but to show the reliability of the data on the
19 work that they've done to try to put those
20 data into a better database. So, you know
21 there are options to do that when there are
22 good data available that could be made better

1 that could be brought to bear for that.

2 MS. MAINO-FIKE: Well, I see that
3 as another piece of NQF's value equation. If
4 NQF and this group is in a position to
5 standard measures around, you know things like
6 that, it could be another piece of the value
7 equation.

8 I know you've been trying to say
9 something, Ron. Sorry.

10 MEMBER BIALEK: I always try to
11 say something.

12 A comment that Kurt made earlier
13 and something that Matt has said, as well as
14 Paul made me think about another potential
15 stakeholder/customer/funder group which would
16 be the conversion foundations. And that
17 they're struggling with how to invest the
18 dollars that they have to invest in
19 communities to make a difference in terms of
20 health. And they go back to traditional
21 measures, but they really I think some of
22 them, a lot of them, would like to get a

1 little beyond the traditional but they really
2 don't know how to do that. They don't really
3 have the metrics. And maybe conversion
4 foundations, some of the larger ones or some
5 of them coming together, might be willing to
6 invest in some efforts that really would look
7 at this intersection, develop some measures
8 that they could use for their funding
9 decisions and for their monitoring.

10 MS. MAINO-FIKE: Right. Good
11 potential partner source.

12 MEMBER STOTO: And they've got an
13 organization, the National Network of Public
14 Health Institutes. Isn't that them?

15 MEMBER BIALEK: Not the conversion
16 foundations. A lot of those belong to grant
17 makers and health.

18 MEMBER STOTO: Okay. That's what
19 I thought that that group was.

20 MEMBER BIALEK: And NNPHI
21 Institutes.

22 MEMBER STOTO: Okay.

1 MEMBER PESTRONK: Quasi-
2 governmental or nonprofit organizations that
3 states or locals create to get their business
4 done or to do work that a governmental entity
5 would have difficulty doing.

6 MS. MAINO-FIKE: Well let me ask
7 this: What you've got here is a nice list of
8 areas that need to be or could be looked at,
9 strategic objectives to improve the likelihood
10 and data of what you would be getting back
11 from any sort of measures or call.

12 MEMBER STOTO: Go ahead, Matt.

13 MS. MAINO-FIKE: Nothing like two
14 Ms.

15 MEMBER STIEFEL: Just one other
16 thought on the value on the value proposition
17 is this idea of leveraging requirements. That
18 historically, I think that's where NQF's value
19 propositions come from is that NCQA values the
20 NQF endorsement in its role to serve as a
21 measure developer and creditor and all the
22 rest. And the same thing can apply here as

1 sort of that that's why the Community Needs
2 Health Assessment came is the health care
3 system is being told to do this.

4 Sarah mentioned the health care
5 organizations are driven by CMS requirements.
6 I mean, that's why we're doing health risk
7 assessments for seniors and that's why we do
8 the HEDIS measures and all, and the Medicare
9 STAR.

10 So, really I think sort of taking
11 advantage of leverage, leveraging
12 requirements.

13 MS. MAINO-FIKE: Thank you.
14 Adding those to the notes?

15 Yes, Michael?

16 MEMBER STIEFEL: I just want to
17 say that at the top of this thing it says
18 here, you know it says this is all assuming
19 that we're going to issue another call. And
20 it strikes me that after we do all these
21 things we may decide that issuing a call is
22 not the right way to proceed, but that there's

1 really a different way of working with this
2 kind of community.

3 MS. MAINO-FIKE: Good point. Well
4 said.

5 You know for purposes of getting
6 this information we said let's assume that
7 we're going to issue another call. What would
8 we do differently? You know, lessons learned.
9 Knowing what we know, what would we do
10 differently?

11 So, the decision has not
12 necessarily been made to issue another call.

13 MEMBER STOTO: My point is that
14 after doing all this work which I think is the
15 right thing to do, we may decide that issuing
16 calls isn't the right way to identify measures
17 to endorse.

18 MS. MAINO-FIKE: Right.

19 MEMBER STOTO: That that way of
20 doing business may not be the right way in
21 this new space.

22 MS. MAINO-FIKE: Right. And so

1 perhaps another way to reframe this work is to
2 say a potential approach to entering -- I'm
3 just kind of talking off the top of my head
4 here -- to entering into the measures of the -
5 -

6 MEMBER STOTO: Yes. Presuming NQF
7 will eventually want to endorse population
8 health measures --

9 MS. MAINO-FIKE: Okay.

10 MEMBER STOTO: -- what do we need
11 to do to get to that point.

12 DR. BURSTIN: I think we probably
13 just made too many assumptions that the pump
14 was quite primed, and it clearly was not. So
15 I think there's a lot of lessons learned for
16 us about being -- you know before we actually
17 did this again being very clear that there
18 would in fact be measures available. But
19 again, and it may not be totally ready yet,
20 but if you think about if we're doing
21 cardiovascular in 2013, which we will be in
22 the early part of the year, there's some great

1 opportunities to potentially bring in some
2 population level cardiovascular health metrics
3 to that project.

4 So, I guess I'd also like this
5 group to help us think through what would we
6 do in a project like that to ensure that some
7 of those really important measures come in at
8 the community level. I mean, we looked at the
9 AHRQ Prevention Community Indicators last
10 year, whatever it was, in the cardiovascular
11 project about hypertension, CAD, issues like
12 that about avoidable hospitalizations in
13 cardiovascular. But, you know maybe there are
14 some other ones. Like I know, you know Peter
15 Briss is looking for a population level blood
16 pressure screening measure for the Million
17 Hearts Campaign. It needs to be done, it
18 needs to be brought in soon. That's something
19 that, obviously, I think you know a
20 Cardiovascular Committee could probably handle
21 if we kind of get some smart folks like you
22 guys potentially at that table. And I'd like

1 to know what you think we'd need to do to make
2 sure that could happen in a project like that.

3 That HIV measures would have flown
4 through our infectious disease projects in two
5 weeks, I can tell you that. No problem. It
6 would have gone right through. There would
7 have been great -- like the level of analysis
8 at the community, this is perfect, this is
9 really informative. No one would have blinked.

10 So, just some thoughts.

11 MS. MAINO-FIKE: Sarah?

12 MEMBER SAMPSEL: So kind of in
13 response to that, but also you know this is
14 response to what Paul said earlier about, you
15 know kind of NCQA submitted the BMI measure,
16 you know the same old BMI measure.

17 I'm just wondering if, you know
18 when we started last fall we looked at the
19 standard NQF criteria and then adapted it, you
20 know tweaked it a little bit for population
21 health. And, you know I wonder if we did kind
22 of a little bit of a disservice to ourselves

1 by doing that where what we could do is just--
2 so for this cardiovascular call, you know kind
3 of make it clear that we're not -- you know,
4 we're looking for measures that are
5 translatable at a larger population health
6 level and, you know there's a box they check.
7 This is for a specific subgroup or this could
8 be a population health level measure.

9 Something like that, they've got
10 people to think they could choose population
11 health? Okay.

12 DR. BURSTIN: Yes. Our current
13 submission forms clearly allows you to say
14 clinician, health -- and you know for all the
15 behavior health forms we just brought in on
16 schizophrenia, they all just said state. So
17 that's fine, which is why the Committee was
18 like sure these seem like great metrics to do.
19 I'm not sure if I'd feel comfortable with the
20 risk adjustment at my clinical level, but at
21 state Medicaid level those seem great.

22 So, again, you know that's already

1 an option.

2 MEMBER SAMPSEL: But I'm just
3 wondering if it's clear enough that people
4 understand how to translate that when they're
5 submitting?

6 MS. MAINO-FIKE: It could need
7 some re-emphasizing or clarity around it.

8 MEMBER PESTRONK: So that is the
9 second of the -- adapting the second of the
10 strategies for use in existing work groups
11 because what we've discovered through this
12 process is that the guidance and the
13 definitions were not helpful enough. They
14 were as good as we could make them at the
15 time, but they weren't good enough. And so if
16 you're going to go back into that blood
17 pressure group, you would want to give that
18 blood pressure group, both the working group
19 and then the customer -- the measure definers
20 or suggesters, you'd have to give them a whole
21 lot more orientation, right?

22 DR. BURSTIN: Three one-hour

1 telephone calls with them already, yes. There
2 were.

3 MEMBER PESTRONK: Yes.

4 MS. MAINO-FIKE: Okay. Oh. I'm
5 sorry, Kurt?

6 CO-CHAIR STANGE: So what did we
7 learn from your experience with the
8 Disparities Work Group? And what actions
9 proposed, possibly Helen is getting population
10 and disparities groups together. I think a
11 similar crosscutting strategy for the
12 disparities and for population health to just
13 make that part of all calls or --

14 DR. BURSTIN: Yes, I mean, it's a
15 very interesting question. I mean much of the
16 work I think we'll do in disparities going
17 forward is in fact stratifying quality
18 measures as opposed to new de novo measures.
19 We brought in measures this time that are more
20 cultural competency, access to language
21 services; things like that. But I think at
22 some point you don't have as many of those

1 crosscutting disparity measures and you really
2 do focus on the stratification of quality
3 measures. So, we are happy to take those
4 measures in any project when they come in.

5 Similarly, resource use. You
6 know, I'd rather not necessarily do another
7 cost specific project, but it's easy to see
8 how you might bring in resource use specific
9 measures in a lot of these different areas
10 going forward.

11 CO-CHAIR STANGE: So that's kind
12 of taking the measure at the current level and
13 stratifying down?

14 DR. BURSTIN: Yes.

15 CO-CHAIR STANGE: Is the
16 population health taking the current measure
17 and stratifying up to a clinical population
18 level but then also thinking about a
19 geographic community level and a system level?
20 I mean, is that one way to -- would guidance
21 stratifying down and stratifying up be helpful
22 for the other efforts?

1 DR. BURSTIN: A rolling up and a
2 rolling down, yes.

3 MEMBER STIEFEL: Thinking about
4 the call for cardiovascular measures is an
5 extremely interesting potential opportunity.
6 Some of us participated in the NPP group that
7 developed these recommendations to CMS and we
8 came up with that three part frame of
9 interventions at the social, community,
10 economic level. Interventions at the
11 behavioral level. And interventions at the
12 clinical preventive services level. And by the
13 way, that framework was in our call for
14 measures, too. It seemed it was ignored.

15 But that would be really
16 fascinating to apply to the call for
17 cardiovascular measures to have those three
18 categories of the social, environmental,
19 behavioral and clinical preventive services.
20 It might be a great opportunity to further the
21 population health measures through the
22 cardiovascular measures channel.

1 CO-CHAIR JARRIS: So if we did
2 this right, every call for measures would
3 include those three levels? And the other
4 thing which we were unable to get -- it got
5 sort of rejected by the overall NPP, is we
6 wanted to create -- some of us wanted to
7 create a goodness and fairness measure so that
8 you have -- this is the 2001 concept from the
9 World Health Organization. Goodness is the
10 overall performance at that population level.
11 Fairness is the difference between the most
12 healthy and least healthy group on that
13 measure in a population. That was rejected as
14 too new of a concept.

15 We read different stuff, I guess.
16 But I think ideally that would go into every
17 measure to get at health equity. If you're
18 going to put out a cardiovascular measure, you
19 put in the goodness and fairness, okay?
20 What's the rate of MIs among the population
21 and what's the gap between -- I don't know if
22 it's Caucasian and African-American and the

1 population, whatever the appropriate
2 populations are.

3 DR. BURSTIN: And we do require
4 that measures that are for maintenance provide
5 back that stratified data. So the
6 Cardiovascular Committee reviewed every single
7 measure stratified by race and ethnicity when
8 the developers had access to it. So all of
9 those CMS core measures were produced,
10 stratified first --

11 MS. MAINO-FIKE: Excuse me once
12 again.

13 In goodness, fairness, because I
14 want to make sure we capture this
15 appropriately on those three different levels,
16 which was behavioral I believe was first and
17 clinical and what was the third?

18 MEMBER STIEFEL: Social and
19 environmental.

20 MS. MAINO-FIKE: Okay. But we
21 just want to make sure that that's another
22 area where can we -- it parlays into all other

1 measures.

2 DR. BURSTIN: So just to answer
3 Paul's question, so essentially the various
4 cardiovascular measures, aspirin use, beta
5 blockers, et cetera, for a measure that was up
6 for maintenance the developers had to submit
7 the data showing, like what you looked at
8 yesterday, essentially NCQA stratified it for
9 you by Medicare, Medicaid commercial and you
10 could see those differences laid out for the
11 NCQA measures yesterday.

12 CMS has data to be able to in fact
13 pull it out by race. So they were actually
14 able to give the Committee the differences by
15 race and ethnicity, it's 80 percent for
16 whites, it's 70 percent for Hispanics and it
17 was 50 percent for African-Americans. And a
18 couple of times a couple of measures we
19 thought were otherwise topped out, in fact
20 when you dived deep there are some populations
21 who are still at risk. Right, absolutely.
22 Yes.

1 MEMBER STIEFEL: It has all kinds
2 of interesting I think positive attributes.
3 It makes the case much more clearly about the
4 relevance of the upstream determinants. As
5 opposed to talking in general about population
6 health, we're talking about, you know, very
7 specifically cardiovascular disease. And it
8 may engage people in a different way, and
9 especially if you call for measures in those
10 three categories.

11 CO-CHAIR JARRIS: That's also why
12 we got to get away from -- okay, renal
13 disease, you know, was whatever a specific
14 test done on patient's renal disease by this
15 doctor as the measure and go to what is the
16 incident or prevalence of renal disease and
17 then break that out by racial and ethnic
18 groups to demonstrate the huge difference with
19 hypertension between African-American renal
20 disease and Caucasian American. But if all
21 you're doing is measuring the did you
22 prescribe a ACE inhibitor or whatever, you're

1 never going to get at that gap in the
2 population.

3 CO-CHAIR STANGE: Helen, what are
4 you doing with multi-morbidity?

5 DR. BURSTIN: It's a tough one.
6 We actually just put out a framework just in
7 the last few months, actually. We should
8 share it with SCRIP. I think they did a nice
9 job with it. Hopkins helped write a
10 background paper for us on how to approach
11 patients with multi-chronic conditions, and it
12 was a lot of getting at some of these big
13 picture issues and also just thinking
14 differently about the sort of single focus
15 diseases and how you might look at that
16 population more in terms of function and
17 health rather than disease by disease.

18 CO-CHAIR STANGE: So that's a ripe
19 population for it?

20 DR. BURSTIN: Yes.

21 CO-CHAIR JARRIS: It occurs to me,
22 it came up earlier is you know, the approach--

1 the multi-chronic disease approach. The
2 simplest way to do that is to say multi-
3 chronic disease, that means you have multi-
4 chronic diseases so we'll treat this person as
5 three diseases. Well, does that actually
6 create wellness in a person if you treat their
7 three diseases?

8 And the same thing happens here.
9 If you look at a population, is it simply
10 treating the rates or quality of diseases in
11 that population or is the health of a
12 population something more than a collection of
13 diseases? And that's where we start to get
14 into that concept of well-being in the
15 population health group. But I think that
16 well-being is not diseases, and that's where
17 we miss on all of these.

18 MS. MAINO-FIKE: I'm going to do--

19 CO-CHAIR STANGE: The multiple
20 chronic conditions is a fertile ground for
21 making that point. The reason we kind of
22 resisted it as a Committee I think this idea

1 of just doing it a disease a time is exactly
2 that concern, but that this is a way that you
3 could normalize the population health focus
4 with the disease focus. I mean, multiple
5 chronic conditions has an incredible amount of
6 legs right now. So that would be a way of
7 getting the broader whole person focus and
8 then population --

9 CO-CHAIR JARRIS: And
10 unfortunately population health was considered
11 outside the scope of that work at HHS. It was
12 clinical. There was a paper put out, an
13 initiative by HHS on multiple chronic diseases
14 and we got very early copies and tried to work
15 with them, and they kept insisting, "No, I'm
16 sorry, population health and public health are
17 outside the scope of this. This is clinical."
18 And it was a huge missed opportunity.

19 MEMBER STOTO: I think that kind
20 of thinking that the population health is
21 clinical and it's separate is a big problem.
22 But, you know it's common and it runs all the

1 way through these.

2 MS. MAINO-FIKE: Do we have that
3 up here as the whole notion of providing
4 clarity on definitions that we're using? Is
5 that up here somewhere? Because I think
6 that's another action item that would be
7 important in soliciting or making any calls
8 for measures.

9 MEMBER PESTRONK: In the framework
10 that I had it was part of number two. It was
11 part refining guidance and definitions.

12 MS. MAINO-FIKE: Okay. Good. Good.

13 You know, I'm going to do a time
14 check right now. As it stands, I think we've
15 done a good job of discussing what are some of
16 the things that need to change that we could
17 do better in sending out a call for measures?
18 Any call for measures, really. It's a fairly
19 broad list.

20 In terms of wrapping things up,
21 what might be useful we talked about is
22 looking at this list and putting together

1 perhaps some chronology of what might need to
2 be done. Some of these items may be able to
3 be done together. But what you want to do at
4 the end of the day is this group has the
5 funding for a couple of more months, if I'm
6 correct. Helen, I'm going to double check
7 with you. So how do you want to use your
8 time? How do you want to use that time? And
9 it may be you can take some action against
10 some of the things on this list.

11 DR. BURSTIN: Some of this is
12 just, you know in our current project. But I
13 think a lot of what we've talked about is what
14 would future initiatives be both specific in
15 this area as well as potentially thinking
16 about how to build this into another projects
17 going forward.

18 MS. MAINO-FIKE: Yes. Do you feel
19 -any thoughts on how you want to use your time
20 as a group over the next couple of months?
21 What are your thoughts there? I'm going to
22 kind of ask the Steering Committee for their

1 thoughts as well.

2 Okay. You're going to let Matt go
3 first?

4 MEMBER STIEFEL: One idea, maybe,
5 would be to review the compilation of measures
6 and maybe start with a subset of measures, but
7 you know to do the side-by-side kind of
8 evaluation not calling for measures, just
9 reviewing the existing set of measures to see
10 where the overlaps and discrepancies are.
11 That could be a very useful contribution.

12 CO-CHAIR JARRIS: I wonder as part
13 of that if some of the measures had potential
14 to be turned into population health measures,
15 whether any feedback could go to those measure
16 developers to say have you thought about this?

17 MS. JACOBSON: This is Dawn.

18 Can I make one comment in
19 reference to the background paper?

20 MS. MAINO-FIKE: Certainly.

21 CO-CHAIR JARRIS: Go ahead.

22 MS. JACOBSON: Okay. And this goes

1 back to the low-hanging fruit question, or
2 need to identify that.

3 We didn't get a chance to talk
4 about this a lot on our previous call, but in
5 December what I did is I took what I
6 considered the 26 kind of go-to indicator sets
7 from health care and public health and I did
8 go through and find the common low-hanging
9 measures. And those are in Tables 2 and 3,
10 sort of by domain and then overall.

11 And just by default, the Committee
12 comes up with a lot of them that are on there.
13 I know that you talk a lot about infant
14 mortality and prenatal care, you know, tobacco
15 obviously is on there and all of the
16 behaviors that are common on the table.

17 But in addition to those tables
18 which, you know that is a qualitative
19 assessment and it was sort of a research
20 approach, and we can talk more about the
21 methods if you want to going forward as to how
22 I got those lists. But then on page 35 as

1 well, and I don't know if you have the whole
2 report there, we did a synthesis table where we
3 took the low-hanging fruit, the measures that
4 are very, very commonly measured from both
5 clinical care system and then sort of the
6 government indicator HealthyPeople type
7 reports and put them next to a column that
8 said who would then potentially lead
9 interventions or health improvement activities
10 for those measures.

11 And so examples are like
12 hospitalizations for cardiovascular disease,
13 timeliness of diagnosis and treatment for
14 cancer within the clinical care realm.
15 Exposure to secondhand smoke in the physical
16 environment, just more a public health sort
17 of, they take on interventions as leaders.

18 So I just want to say that some of
19 that work has been done, it might just be
20 revisiting and talking more about the methods
21 that led to the table to really be comfortable
22 with seeing that it's some of the low-hanging

1 fruit.

2 And then the other second comment
3 I would really like to make is we put a
4 recommendation in our paper to use existing
5 indicator sets. So a lot of what's being
6 discussed today was part of the Federal
7 Advisory Committee for HealthyPeople, was part
8 of what IOM discussions that lead to the
9 indicator reports. It was the same sort of
10 partners that come to the table and talk about
11 that.

12 So I just would like to put out
13 there is the leading health indicators, they
14 have valid data sets. You know it's been
15 thought through before. So rather than
16 recreating the wheel, I'm just wondering if
17 there's a way to keep what already exists that
18 have been put through a prioritization level?

19 MS. MAINO-FIKE: Matt, did you
20 have something you wanted to add to that?

21 MEMBER STIEFEL: I just think it's
22 a great idea. I think as a starting point, I

1 think there could be additional work to go to
2 the next level of review of reviewing the
3 measure specifications. This is still just a
4 kind of side-by-side, but the devil's in the
5 details with these. But it would be a great
6 place to start from, I agree.

7 MS. MAINO-FIKE: Okay.

8 CO-CHAIR JARRIS: So for
9 illustrative purposes it might be helpful to
10 take the three levels that came out of NPP and
11 take the given measures and put them at the
12 level they're at, which would clearly show us,
13 you know one of these -- that there's very few
14 at those higher levels, but just to point out.
15 And then to maybe take some of them and say
16 "Here would be the potential with this
17 cardiovascular measure to go to these next two
18 levels." That sounds like a great project for
19 a --

20 MS. MAINO-FIKE: So let's write
21 that down as our next step for a person. I
22 think that's another option for a next step.

1 I know we have until 2:30. What
2 I'd like to end with is take that time to come
3 up with ideas for what you think those next
4 steps could and should be. Again, another way
5 to say that is how this group might use the
6 rest of its time as a group and make some
7 suggestions. Assuming, you know, we don't
8 have to go until 2:30 if people don't -- if
9 we're all out of ideas. But we have up until
10 that point to decide how you want to use your
11 time for the next several months.

12 So what else do we have to add to
13 that list?

14 DR. BURSTIN: One suggestion might
15 be, it might be interesting for us to share a
16 couple of calls for measures that are going
17 out shortly in other areas, like infectious
18 diseases and see if there's a way to sort of
19 write that to make sure some of this flavor
20 comes through. And we template those. We add
21 the clinical stuff in, but they're fairly
22 templated. It might just be an opportunity

1 for us to think about how to take the
2 influence of this group to spread it more
3 broadly.

4 MS. KHAN: That sounds like a good
5 idea. I would add that to another future
6 activity. Yes. So take the lessons learned
7 here on other calls that are going out.

8 Yes. Ron?

9 MEMBER BIALEK: I would like for
10 us to think a little bit more about how we can
11 integrate the consensus, HHS consensus
12 document or the Quality Aims for Public Health
13 into what it is that we're requesting measure
14 developers to be thinking about and reporting
15 on.

16 I don't have a real clear idea in
17 my mind, but I think those quality aims do
18 line up fairly well with the health care
19 quality aims and, you know is there some way
20 for us to think about their use in this
21 process?

22 MS. MAINO-FIKE: Okay. So another

1 good next step, quality aims integrated with
2 requests for measures.

3 CO-CHAIR JARRIS: We share other
4 calls for measures also. As I understand it
5 included perhaps development of template
6 language around population health to be
7 inserted into other measures, other quality
8 measures.

9 MS. MAINO-FIKE: Yes. Right.
10 Thank you. Good point. All right.

11 What other ideas do you have for
12 how this Committee could use its time over the
13 next couple of months?

14 CO-CHAIR JARRIS: I would like to
15 hear from the Health Disparities Work Group
16 and compare notes with them. Because they
17 must be having similar issues.

18 MS. MAINO-FIKE: Okay.

19 CO-CHAIR JARRIS: Most of what
20 effects health as far as outside of the four
21 walls, it's not just a matter of street to
22 cath time for different populations.

1 MS. MAINO-FIKE: Right. So hear
2 from the Health Disparities Work Group? Good.
3 What their challenges are, how they're
4 approaching them? Okay.

5 What else might you want to do
6 with your time?

7 CO-CHAIR STANGE: Is there a
8 similar opportunity with the multiple chronic
9 conditions group?

10 DR. BURSTIN: It's done.

11 CO-CHAIR STANGE: Okay.

12 MS. MAINO-FIKE: So with the
13 multiple chronic conditions group, what do you
14 think, Helen?

15 DR. BURSTIN: The Committee's
16 done. They've finished their work, the final
17 product is done. We could share the work if
18 you want to talk to the Chairs or something,
19 I'm sure we'd be happy to get that pulled
20 together for you.

21 MS. MAINO-FIKE: Okay.

22 CO-CHAIR JARRIS: What about

1 others folks working in this area, like CMMI,
2 hearing from them, what they're struggling
3 with. And there may be other -- I mean NCQA
4 looking at this area? Is IHI looking in this
5 area? Anybody else looking at population
6 health and where are they stuck?

7 MEMBER PESTRONK: AHRQ is looking
8 at it through their own lens. NIH is looking
9 at it, you know, through their own lens.

10 DR. BURSTIN: NIH has done a very
11 nice convening activity this last year on
12 healthy behaviors that should be put into
13 primary care practices routinely. That work
14 was really nicely done.

15 MS. MAINO-FIKE: So the action
16 item there would be --

17 CO-CHAIR JARRIS: You know, as I
18 understand it, and I understand very little
19 about NQF's structure, but the NPP assists
20 with the partnership division of NQF. So maybe
21 that would be a forum to maybe convene, if we
22 get funding for them to convene these

1 different stakeholders for a day and spend a
2 day of that group on population health
3 measures. We could report out and these other
4 groups report out. And then there are a lot
5 of mostly health care people there, but a lot
6 of different organizations that could discuss
7 this.

8 MS. MAINO-FIKE: Right. Convene
9 those two groups and maybe have some
10 information sharing, you know report outs
11 might be something that you could do. Yes.

12 CO-CHAIR JARRIS: Report back to
13 the NPP since the first work in NQF I think
14 was done there about, okay, here's what we ran
15 into so you can be aware of what's going on in
16 this area. And if that process is doing
17 something.

18 DR. BURSTIN: And we all work very
19 collaboratively, something we could do with
20 NPP with Carrie and Wendy.

21 MS. MAINO-FIKE: Well, I see this
22 as something you could call -- you probably do

1 this with all of your working groups, but you
2 know a lessons learned after you've completed
3 your task, that then you share with other work
4 groups regardless of what their topic was
5 because there may be a lot of overlap. So
6 maybe it's formalizing a lessons learned
7 session.

8 CO-CHAIR JARRIS: I also wonder if
9 we have different mechanism then the work
10 group or the Committee here. And one of the
11 ideas from the morning was doing this
12 environmental scan. We've already done a
13 little bit of an internal scan. But not just
14 to do that to get something you can put in a
15 white paper and plot in front of a group, but
16 doing that as an interactive field
17 relationship building process. And if that's
18 something you'd have to configure more sexily
19 and non-fractally, but that's something you
20 could actually get funding to do.

21 I mean, how do you make population
22 health measurement a part of what NQF does on

1 multiple levels? How do you bring together
2 these strange bedfellows that actually have
3 some common needs that they don't have a forum
4 for talking with? If you just thought about
5 a roving bee going out gathering information,
6 but that's asking the right questions and
7 saying you should talk to this group. And
8 then something would emerge from that.

9 Shouldn't we ask Dawn if she did
10 that?

11 Dawn, if you're still there, did
12 you do a project -- because some of your
13 question, I thought it was RAND on reaching
14 out to different stakeholders about population
15 health measures to try to describe what was
16 out there? Are you aware of that or was that
17 you that did that?

18 MS. JACOBSON: No. That was not
19 me.

20 CO-CHAIR JARRIS: Thanks.

21 MS. JACOBSON: And I think Nicki
22 Lurie did that before she left.

1 MS. MAINO-FIKE: Yes. So there's
2 that opportunity to put together an
3 environmental scan and gather those folks
4 together.

5 Anything else that you can think
6 of you want to put down as options for how you
7 use the rest of your time together?

8 I feel like Carol Burnett "I'm so
9 glad we had this time together."

10 How do you want to use the rest of
11 it, not that this isn't a good list already?

12 CO-CHAIR JARRIS: But what do we
13 do with this list?

14 MS. MAINO-FIKE: Well, I think the
15 point of creating it is to give the Steering
16 Committee and the Board an opportunity to
17 decide okay, you know let's prioritize, let's
18 see what we have the funding for.

19 DR. BURSTIN: It's been a really
20 rich discussion. I personally have taken --
21 what did I take? Twenty -- what is it 22
22 pages of notes. So, I sort of feel like it's

1 something we need to process, go through all
2 this, see if we can coordinate it a bit. I
3 tend to think while I type. So if I type it,
4 I learn it and think about it.

5 So, you know I think we need to
6 process it, think it, bring back some options
7 to you, talk with HHS, see what options are
8 moving forward.

9 You know, I think there were some
10 great suggestions today of things that I think
11 I'd like to move on, at least. But I think
12 there are some really potential things that I
13 think no one would argue are logically things
14 where NQF could add value.

15 MEMBER STIEFEL: What's the timing
16 for the call for cardiovascular measures?

17 DR. BURSTIN: I don't even know
18 yet. 2013, so it's months and months. It's a
19 fair amount away. Infectious Disease was just
20 put forward. GI/GU is going out shortly. So,
21 you know most of the other clinical projects
22 will start in the fall.

1 MEMBER STIEFEL: Because I don't
2 know if it's listed up there, but one of the
3 things we could do is to kind of create the
4 language for the population health view of all
5 the upcoming calls for measures.

6 DR. BURSTIN: That's what I was
7 suggesting.

8 MS. MAINO-FIKE: Okay. Good.

9 So what you have done today is, as
10 Helen you said, have a very rich discussion
11 regarding what are some of the reasons that
12 the response was lower than you would like for
13 the call for measures. But more broadly, what
14 are some future steps, actions that could be
15 taken to further this discussion around
16 standards and measures in the population or
17 public sector and what might NQF's role be and
18 should and could be in that.

19 You also took a look at -- what
20 was three? What some of the measures should
21 be, there was some further discussion around
22 that and what the parameters are.

1 And after, it was almost like you
2 needed to have that thorough discussion
3 yesterday and today and get all the ideas and
4 perspectives out, which I think enabled you
5 then to have more of a concrete conversation,
6 that fishbone exercise around what are some --
7 we ended up with four or five. I guess we
8 ended up with four specific strategies to not
9 just improve what we would do differently for
10 any future measures call, but for any call for
11 measures that NQF would put together.

12 And against those five strategic
13 areas, we delved into a little more detail
14 against kind of that environmental scan of who
15 is in the environment that we might want to
16 consider as partners.

17 You've also delved into a little
18 more detail around NQF value propositions and
19 how to phrase that for your current
20 constituents as well as some new constituents
21 that you're looking at taking on.

22 And then finally you came up with

1 a list of potential next steps or action steps
2 that this group could take in the time that it
3 has left together.

4 So, I think that's a pretty good
5 job. I applaud all of you. Next steps, as
6 Helen said, was to kind of digest all of that
7 information and decide where you want to go
8 with it, particularly those potential next
9 steps for this group.

10 One thing you will be receiving is
11 a list of this, future activities as well as
12 the five key strategic areas. You'll receive
13 a copy of that.

14 I think you'll receive a copy of
15 the minutes or the notes as well, is that
16 right? Okay. All right.

17 With that, I am going to ask Elisa
18 where you want to go with the program as far
19 as the agenda for the rest of the day. We've
20 worked pretty hard so far.

21 MS. MUNTHALI: We have. And I know
22 we have a hard stop at 3:00 because folks are

1 trying to get out and take flights.

2 So the next agenda item that we
3 have was to revisit the recommendations from
4 the Commission Paper. And will put Amir on the
5 spot, because he is the Committee member. I
6 did warn you, though, that I was going to put
7 you on the spot. And he was the Committee
8 member that suggested that we place this on
9 the agenda. And if you don't have a pressing
10 need to revisit --

11 MEMBER QASEEM: These
12 recommendations, some of them were very good.
13 But I felt like, I think, maybe this is an
14 opportunity for NQF to adopt some of them if
15 you feel like some of them are important.
16 Especially I think Kurt was talking about this
17 as well. And I mentioned it a little bit at
18 how we're measuring this population health and
19 total population health. And I haven't looked
20 at these recommendations for a while, but
21 there was a recommendation in there about
22 systems or as well as how to look at the total

1 population health. I wish I had -- I don't
2 know which one I'm talking about. But
3 essentially conceptually I do think that we
4 should look at these.

5 There are some recommendations
6 that may actually be missing from this, which
7 I think would have been part of it. And I
8 don't know how the group feels about them.

9 And then of course, if we do
10 decide to adopt some of these recommendations,
11 may need to be rephrased because they're not
12 really -- I don't know how to even interpret
13 some of them. So that's essentially what my
14 point was.

15 And I will quickly look at it,
16 there was a specific point I was -- okay.
17 Number 2 and number 3. So that was the ones.

18 Since the determinants of health
19 are conceptually envisioned at the total
20 population level, it is recommended that in a
21 measurement framework we find that when
22 determinants of health at the total population

1 as well. The current categorization of
2 clinical care, behavior, social environment,
3 physical environment should be used by
4 organizations interested in improving total
5 population health. And that was sort of a
6 concept that I was talking about this morning
7 as well that, you know the performance
8 measures are at a lot of different levels,
9 structured process blah, blah, blah. And I
10 think we really need to start looking at all
11 of them together rather than separate because
12 I still feel like that's what the folks out
13 there are doing. And just because you're
14 going to improve process is not going to lead
15 to the improvement of total population health.

16 That's it.

17 Sorry, guys. I have to leave. And
18 thank you so much to see you all.

19 DR. BURSTIN: It may be an
20 exercise that people would like, we could just
21 share those recommendations probably and ask
22 people to submit comments as to whether there

1 are ones that they think should be
2 specifically adopted as sort of more oomph
3 than just being in a Commission Paper.

4 MEMBER QASEEM: Because my fear is
5 that this paper is otherwise going to get lost
6 because it's just -- you know it's an NQF
7 Commission Paper, but if NQF adopts some of
8 the recommendations, it's going to carry much
9 more weight than just --

10 DR. BURSTIN: And we will be
11 putting out a phase 2 report, of course, with
12 the measures that you have reviewed this
13 round. So we will have the opportunity to
14 include anything you'd like in there about the
15 process, what we've learned. I mean, I think
16 it would be nice to actually share some of the
17 discussion from today potentially as well, and
18 then you think if there are some of these that
19 you would like to include there as well, we
20 can put that out for comment.

21 MEMBER BIALEK: Helen, do
22 Committees ever submit recommendations to the

1 Board requesting that the Board adopt them?

2 DR. BURSTIN: Yes. So frequently
3 Steering Committees will make a series of
4 recommendations about a given topical area of
5 what should happen moving forward. And those
6 will move forward and CSAC usually discusses
7 them first. And then if it's something that
8 has policy implications, it will go the Board.

9 MEMBER PESTRONK: Is the
10 Commission Paper a public document? Is it
11 available to be distributed broadly, you know,
12 to our own constituencies and to others?

13 DR. BURSTIN: I'm going to defer
14 to Elisa on that one.

15 MS. MUNTHALI: Sorry.

16 DR. BURSTIN: That's okay. What's
17 the status of the public availability of the
18 final Commission Paper?

19 MS. MUNTHALI: Actually, it's
20 done. We should be posting it Monday
21 probably. So we have the final product.

22 MEMBER PESTRONK: Could you email

1 us all a copy?

2 MS. MUNTHALI: Yes, we will. We
3 will email it to you.

4 MEMBER PESTRONK: And so then at
5 that point we're free to share it and
6 encourage people to read it?

7 MS. MUNTHALI: Yes.

8 MEMBER PESTRONK: Okay.

9 CO-CHAIR JARRIS: Anything else we
10 should discuss?

11 MS. MUNTHALI: Just one thing. We
12 just want to give an opportunity to our
13 members and to the public to provide comment,
14 which we're sorry we didn't do before.

15 Anika?

16 OPERATOR: At this time I'd like
17 to remind everyone in order to ask a question,
18 press star, then the number one on your
19 telephone key pad.

20 At this time there are no
21 questions.

22 MEMBER PESTRONK: So may I thank

1 the Co-Chairs. Talk about thankless work.

2 Done with fine spirit. Thank you very much.

3 Thank you to the staff as well.

4 MS. MUNTHALI: And just a few last
5 minute items before we leave.

6 Staff is going to follow-up with
7 developers, and that would be Legacy.

8 I just wanted to remind everyone
9 that the Steering Committee recommended four
10 measures for endorsement. So those will go
11 through the consensus development process.

12 And we will follow-up with Legacy,
13 work with Ron to make sure that we can get
14 some responses to the concerns that you have,
15 and we'll make sure that we get back to you
16 with that.

17 As Helen mentioned, we're going to
18 be drafting the technical report for phase 2.
19 And we hope to post that report for our member
20 and public comment on June 21st, and that will
21 be a 30 day comment period.

22 And before we do that we'll make

1 sure that you see the report so that you have
2 a few days to give us feedback.

3 And then we hope to have a
4 conference call to adjudicate the comments
5 during the week of July 30th. We'll confirm
6 that. We send our Survey Monkey with probably
7 three tentative dates and ask you to select
8 from that.

9 And the report will include your
10 recommendations and the discussion that you
11 had yesterday and today, the evaluation
12 ratings and the measures that you didn't
13 recommend with the rationale, and the measure
14 specifications for all of the measures.

15 So, we just wanted to thank you as
16 staff, and the Co-Chairs as well. This has
17 been a great meeting for us and we really
18 appreciate the time that you've taken to be
19 with us. Thank you very much.

20 CO-CHAIR JARRIS: And thank you,
21 Elisa and Kristin and of course Helen for all
22 the work that you put into this. I don't

1 think we're always an easy group to handle,
2 but you got us here.

3 DR. BURSTIN: Thank you to
4 Lorraine.

5 (Whereupon, the above-entitled
6 matter went off the record at 2:31 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Population Health
Steering Committee

Before: NQF

Date: 05-31-12

Place: Washington, DC

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