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

C-O-N-T-E-N-T-S

P-R-O-C-E-E-D-I-N-G-S

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

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

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

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

Elisa, did you --

MS. MUNTHALI: Thank you, and

welcome back.

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

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

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

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

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

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

There were five measures that were not recommended for endorsement.

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

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

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

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

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

endorsed measure from NCQA.

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

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

MS. MUNTHALI: Okay. Sorry about that.

MEMBER SPANGLER: Okay.

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

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

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

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

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

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

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

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

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

MEMBER STOTO: Okay.

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

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

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

It took several months to finalize the call, and this was due in part to the delay in the paper development. But we felt that it was important to wait for this work because it was informative to developing the call. And since this was the first time that NQF had put out a call on population level measures we wanted to make sure that we received input and suggestions for refinement throughout the entire development process. And so we got input from our Consensus Standards Approval Committee, which is a standing committee of our Board. So the call was finally posted in early April for 30 days.

Outreach was conducted prior to

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

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

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

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

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

Many of them cited a lack of

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

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

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

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

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

DR. BURSTIN: She's parking.

MS. MUNTHALI: Okay. Great.

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

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

DR. BURSTIN: We do it all the time.

MEMBER BIALEK: Okay.

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

CO-CHAIR JARRIS: And also is can

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

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

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

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

CO-CHAIR JARRIS: Other questions?

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

Peter and Neil, are you on the line?

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

OPERATOR: And that is Peter -

DR. BURSTIN: Peter Briss and Neil Maizlish.

OPERATOR: Okay, thank you.

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

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

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

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

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

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

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

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

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

So, that's an overview.

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

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

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

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

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

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

CO-CHAIR JARRIS: Correct.

MEMBER STOTO: Okay. Thank you.

CO-CHAIR JARRIS: As a measure

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

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

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

CO-CHAIR JARRIS: Any other questions for Peggy?

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

Facilitator, are you --

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

pad.

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

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

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

going to take some time to get over that hurdle.

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

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

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

MS. HONORE: Okay.

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

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

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

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

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

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

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

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

Amir, did you --

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

CO-CHAIR STANGE: This is Kurt.

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

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

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

What has happened over the last

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

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

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

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

CO-CHAIR JARRIS: Matt?

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

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

Paul Stange, are you any relation?

CO-CHAIR STANGE: No.

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

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

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

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

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

Mike?

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

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

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

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

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

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

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

MS. MAINO-FIKE: Thank you.

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

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

organization and happy to be here.

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

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

CO-CHAIR JARRIS: Thanks, Lorraine.

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

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

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

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

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

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

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

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

to take advantage of.

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

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

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

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

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

CO-CHAIR JARRIS: Mike?

MEMBER STOTO: Another idea from

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

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

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

MEMBER STOTO: Sure.

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

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

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

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

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

CO-CHAIR JARRIS: Go ahead, Bobby.

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

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

MS. MAINO-FIKE: Right.

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

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

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

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

MS. MAINO-FIKE: Yes.

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

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

a cycle.

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

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

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

And so I think it's useful to sort

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

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

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

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

health.

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

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

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

MS. MAINO-FIKE: Yes.

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

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

Ron?

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

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

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

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

fit with this?

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

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

then submitting.

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

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

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

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

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

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

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

MEMBER PICKENS: Yes.

CO-CHAIR JARRIS: Okay. All right.

MEMBER PICKENS: Actually, they covered it.

CO-CHAIR JARRIS: All right.

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

CO-CHAIR JARRIS: All right. Can

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

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

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

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

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

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

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

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

Mike?

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

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

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

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

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

MEMBER STOTO: Right.

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

for someone else's benefit?

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

CO-CHAIR JARRIS: Yes.

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

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

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

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

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

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

I'm sorry, did I interrupt you?

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. MAINO-FIKE: Yes, Peter.

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

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

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

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

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

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

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

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

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

MS. MAINO-FIKE: Thank you, Amir.

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

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

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

MS. MAINO-FIKE: Yes.

DR. BRISS: Okay. So I'm Peter

Briss. I'm from CDC.

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

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

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

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

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

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

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

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

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

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

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

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

investment in getting measures endorsed.

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

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

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

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

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

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

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

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

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

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

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

DR. BRISS: I think that's closer

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

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

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

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

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

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

I can get you some information on that.

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

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

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

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

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

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

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

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

MS. MAINO-FIKE: Yes.

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

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

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

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

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

So, is there truly commitment to

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

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

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

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

MS. MAINO-FIKE: Yes.

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

thought I'd comment on that as well.

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

MS. MAINO-FIKE: Good point. Thank you.

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

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

MS. MAINO-FIKE: Yes.

DR. MAIZLISH: Okay. Great.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the information that would support the criteria.

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

framework for evaluating that.

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

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

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

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

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

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

These are some of the --

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

DR. MAIZLISH: Yes.

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

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

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

at that just so that other people can participate.

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

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

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

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

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

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

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

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

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

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

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

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

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

OPERATOR: One moment.

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

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

OPERATOR: Sarah, press star 1.

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

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

MR. CORBRIDGE: Thank you.

Ian Corbridge, can you hear me?

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

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

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

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

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

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

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

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

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

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

MEMBER PESTRONK: Yes.

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

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

MS. MAINO-FIKE: Okay.

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

MS. MAINO-FIKE: Right.

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

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

CO-CHAIR JARRIS: Yes.

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

but has been listening into the discussion this morning.

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

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

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

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

and resources.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

when there are gaps, when we have identified gaps.

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

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

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

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

developer can then come back with fully specified tested measures.

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

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

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

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

CO-CHAIR JARRIS: Yes, we are.

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

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

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

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

DR. MAIZLISH: Okay.

DR. BURSTIN: -- who is very

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

DR. MAIZLISH: Okay.

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

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

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

Committee and staff control and influence and work on that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So by focusing on that sweet spot

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

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

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

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

CO-CHAIR JARRIS: Kurt?

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

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

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

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

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

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

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

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

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

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

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

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

Where we stumbled yesterday was evidence base associated with these

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

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

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

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

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

this morning.

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

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

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

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

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

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

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

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

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

Some of you have come up earlier

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

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

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

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

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

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

MS. MAINO-FIKE: Okay.

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

MS. MAINO-FIKE: Yes.

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

MS. MAINO-FIKE: Yes.

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

MS. MAINO-FIKE: Yes.

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

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

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

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

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

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

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

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

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

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

MS. MAINO-FIKE: Okay.

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

to take a look at.

MS. MAINO-FIKE: Good.

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

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

MS. MAINO-FIKE: Okay.

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

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

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

Under refined guidance --

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

MEMBER BIALEK: Yes.

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

MEMBER BIALEK: And demonstrate value.

MS. MAINO-FIKE: Demonstrate value.

MEMBER BIALEK: Yes.

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

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

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

understanding.

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

MS. MAINO-FIKE: Deadline for responding?

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

MS. MAINO-FIKE: Yes.

MEMBER BIALEK: And I'll stop.

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

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

Provide examples for our

developers.

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

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

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

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

MS. MAINO-FIKE: Yes.

MEMBER STOTO: I mean, it's kind

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

MS. MAINO-FIKE: Yes.

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

MS. MAINO-FIKE: Right.

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

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

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

And you put forth two pieces of --

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

MS. MAINO-FIKE: Yes.

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

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

I know someone over here -- yes? Matt?

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

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

MEMBER STIEFEL: I would say so.

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

MS. MAINO-FIKE: Okay.

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

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

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

MEMBER STOTO: Okay.

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

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

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

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

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

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

MS. MAINO-FIKE: Right.

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

So, create a much more active learning community.

MS. MAINO-FIKE: Yes.

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

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

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

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

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

Because they know how to do this.

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

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

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

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

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

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

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

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

MS. MAINO-FIKE: Yes. Good point.

Sue, are you --

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

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

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

They have had all these national conversations going on.

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

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

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

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

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

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

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

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

MS. MAINO-FIKE: Right.

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

MS. MAINO-FIKE: Right. And most

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

Yes?

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

MS. MAINO-FIKE: Yes.

MEMBER STIEFEL: To get together

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

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

CO-CHAIR JARRIS: Like a datapalooza?

MS. MAINO-FIKE: Measurepalooza?

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

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

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

Paul?

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

can give presentations and a workshop added on to.

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

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

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

We engage the rest of the --

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

I can write them down here. Maybe. Okay.

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

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

And I think funding partners just might be the type of thing that RWJ would be interested in. CDC should be interested. AHRQ should be interested in it. So there's a number of -- we heard that HRSA might be.

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

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

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

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

MEMBER STOTO: Chronic disease probably is the --

CO-CHAIR JARRIS: Yes, chronic disease.

MEMBER STOTO: Yes.

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR JARRIS: Right.

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

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

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

MEMBER PESTRONK: What's an

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

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

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

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

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

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

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

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

What's an example of an academic?

MEMBER STOTO: I would put Wisconsin there.

MS. MAINO-FIKE: Oh, Wisconsin.

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

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

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

MEMBER STOTO: Okay.

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

that's a good point.

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

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

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

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

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

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

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

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

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

they even be on the list, right?

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

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

Ron, you had a comment?

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

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

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

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

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

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

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

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

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

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

health work that NQF is doing.

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

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

groups of organizations for you.

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

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

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

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

call it potential partners.

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

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

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

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

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

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

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

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

Helen, you think we're okay now? Okay.

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

MEMBER PESTRONK: Quality Outcomes Framework?

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

consequences at this point.

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

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

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

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

I'm looking at a time frame. We're supposed to be breaking for lunch two minutes ago. So we'll use ten more minutes.

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

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

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

MEMBER PICKENS: Outside the box

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

MS. MAINO-FIKE: Any others?

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

MS. MAINO-FIKE: Oh.

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

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

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

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

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

MEMBER PESTRONK: Yes.

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

MS. MAINO-FIKE: Right.

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

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

MS. MAINO-FIKE: Yes. Okay.

MEMBER BIALEK: Yes. Yes.

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

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

MS. MAINO-FIKE: Right.

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

MS. MAINO-FIKE: Right. But if we

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

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

MS. MAINO-FIKE: Excuse me one second.

MEMBER PESTRONK: Yes.

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

COURT REPORTER: I'm recording everything.

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

about.

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

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

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

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

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

MS. MAINO-FIKE: Okay.

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

MS. MAINO-FIKE: Right.

MEMBER PESTRONK: -- I don't know.

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

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

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

MS. MAINO-FIKE: Yes.

DR. BURSTIN: And need.

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

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

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

MS. MAINO-FIKE: Yes.

DR. BURSTIN: If their measures

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

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

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

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

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

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

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

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

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

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

They just haven't been pushed.

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

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

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

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

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

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

gave the shot at the visit.

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

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

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

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

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

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

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

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

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

to get that done.

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

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

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.)

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

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

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

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

We want to solicit targeted developers;

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

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

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

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

Providing some technical support, and;

Providing some training or education for developers as well.

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

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

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

We also said establish measure developers from clinical care and public

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

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

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

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

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

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

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

MS. MAINO-FIKE: Under Refining Guidance?

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

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

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

CO-CHAIR JARRIS: It's not the

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

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

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

CO-CHAIR JARRIS: Yes.

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

community understand how that might be relevant to them.

CO-CHAIR JARRIS: Yes.

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

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

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

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

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

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

CO-CHAIR JARRIS: Yes.

MEMBER PESTRONK: So, I'm comfortable.

MS. MAINO-FIKE: Okay. Fine.

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

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

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

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

DR. BURSTIN: I mean, in general

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

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

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

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

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

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

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

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

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

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

DR. BURSTIN: No.

MEMBER PESTRONK: -- that could have extended outreach?

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

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

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

nobody to work with there yet.

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

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

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

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

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

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

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

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

MS. MAINO-FIKE: Right. Right.

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

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

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

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

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

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

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

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

MS. MAINO-FIKE: Right.

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

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

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

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

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

So, yes, Ron?

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

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

MS. MAINO-FIKE: Correct.

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

MS. MAINO-FIKE: Right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Matt?

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

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

Unfortunately, I think hospitals

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

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

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

MS. MAINO-FIKE: Okay.

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

MS. MAINO-FIKE: Yes. Yes. So

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

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

MS. MAINO-FIKE: Yes. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. MAINO-FIKE: Right.

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

Assessment as is the public health entity. So they're like three or four or five different health assessments in the same community.

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

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

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

MS. MAINO-FIKE: I want to capture some of this.

I'm thinking some of this conversation should go under that value proposition or value equation. I'm also thinking that just so you have something concrete to leave this meeting with, that maybe number five here does go back to identifying potential uses and users. And then we specifically identify where some of those areas are.

We already talked about the community hospitals and leveraging what they're doing.

So if we could do that reflected here, that would be great. And then let's -- I know, Matt, you mentioned this. The other thing I'd like to circle back to, people have mentioned this a few times, is coming back to that value equation. We don't need to come up with one value equation, but if we can summarize what that value equation might be,

I think that would make good use of the brain power in this room and help NQF look at making their choice points about how they choose to take action going forward.

So, let's look at that value proposition. We have A, B -- I think we should move this to number 5. What are some further ideas about what the value equation was?

I know we broke for our lunch when, Robert, you were kind of summarizing what you thought NQF's leverage was.

CO-CHAIR JARRIS: One thing we talked about yesterday, which I think would be very helpful, is there are so many surveys out there and data collection tools that all define what they're collecting differently.

MS. MAINO-FIKE: Yes.

CO-CHAIR JARRIS: And that I think would be tremendously valuable if all those different surveys used the same measure so that there's comparability. You could say,

okay, YRBS goes up to age 18, BRFSS starts 18 to 64. So guess what? We now know what happens between this age range as opposed to there's a break in your knowledge because it's a different survey question.

MS. MAINO-FIKE: So you're seeing that as part of NQF's value equation?

CO-CHAIR JARRIS: No, that would be the value of having population measures. You're right. That's not necessarily NQF's --

MS. MAINO-FIKE: Right. So maybe we can add that under NQF value equation is one of the things it could do is to play a role in harmonizing the -- could you say that again, Helen?

DR. BURSTIN: Harmonizing the national survey system.

MEMBER STOTO: And even harmonizing the national surveys among themselves, which --

DR. BURSTIN: I was a fed for seven years; that's not an easy proposition.

We'll be happy to be a partner in that effort.

MEMBER STOTO: Well, I know. Right. And then part of the reason is it's difficult for the feds to do is because everybody's got the same voice. If there were an external group --

DR. BURSTIN: Right.

MEMBER STOTO: -- that could push it, that that might actually make it easier.

MS. MAINO-FIKE: Right. Right. So the value equation is being the outside organization that can get parties together and try to get some standardization.

MEMBER PESTRONK: Who's the customer? Because the value proposition is about who the customer is and what one is trying to sell. So, who's the customer here or who are the customers?

CO-CHAIR JARRIS: In that case it's the users of the survey. Lots of people use it, so I don't how to get more specific. But wouldn't it be nice if the information

from those surveys was clearer or more consistent and had more utility? And that could be public health agencies. It could be clinical folks if they're trying to -- because, you know we have this problem of the public population health doing works at the population level largely through surveys and the clinical sector doing work by adding up individuals. And where will the two ever meet?

MEMBER STIEFEL: I think the customers are the public health entities that you describe, probably federal, state, local and the health care organizations. And if you think of defining customers that way, I think that there's value to each: The value to the public health entities is having this rich vein of data from the clinical care delivery system. And the value to the clinical care delivery system is that with harmonized measures you've got benchmarks to measure your performance against.

MS. MAINO-FIKE: So you're suggesting the customer would be the three different levels of government as well as then the clinical care delivery systems, and that you all could define what the benefits are to each of those customer groups fairly easily?

So can we record that?

MEMBER STOTO: Another value to the clinical health care system is that at some point the IRS might say well the measure that you use in your needs assessment improvement plans have to meet some standards, and endorsement by NQF could be that standard.

MEMBER STIEFEL: Maybe a standard community health needs assessment?

MS. MAINO-FIKE: Yes, Sue?

MEMBER PICKENS: Would there at some point be value to funding agencies like the United Way that when people apply community-based grants to that say it meets NQF population health measures?

MS. MAINO-FIKE: Could that be a

possible next step, or would that be something that you would want to include in a value equation?

MEMBER STOTO: It's another customer.

MS. MAINO-FIKE: It's another customer. Right. So our customers would be the three different governmental levels. If we're just looking at this in a broad way, there'd be the three different governmental levels, there would be the health care delivery systems and could be -- what would you call those? Other organizations that are collecting data? How would you describe them?

MEMBER PICKENS: Well, they're actually funding the projects. RWJ would be one that would fund projects in community and population health. They fund the Wisconsin project, and lots of things. So I would call them -- I'd just call them funders.

MS. MAINO-FIKE: Project funders?

MEMBER PICKENS: Yes.

MS. MAINO-FIKE: Okay.

MEMBER STIEFEL: And I think it's the three different public health levels as opposed to government. Government sounds too big.

MS. MAINO-FIKE: Sounds too Big Brother? So three different -- how would you rephrase that?

MEMBER STIEFEL: Levels of public health organizations.

MS. MAINO-FIKE: Okay. Yes. So like a federal, state and then a local. Okay. Good.

So that helps us a little bit answer the question of who is the customer.

Ron, did you want to add to that?

MEMBER STIEFEL: One of the dilemmas with the users of the measure being the primary customer is how do we sell to developers? Because as Mike pointed out earlier, there aren't that many developers of the population measures and so we have

customers for the measures without necessarily developers.

Now, we heard from two: New York City Health Department and California as potential, both customer and developer. But I still think there's that gap out there of why should an organization spend its time, its money developing a measure that ultimately will be used by folks. So one set of customers, yes, are the users of the measures. Another set of customers that I don't really think we've addressed are the developers of the measures.

MS. MAINO-FIKE: I understand.

Mike?

MEMBER STOTO: I think it's an important point. I think that what we think of as developers and what's the other word? Owners or --

DR. BURSTIN: Stewards.

MEMBER STOTO: Stewards. Might actually have to be rethought in this realm.

So when you have something like say the smoking measure that's used on all kinds of federal surveys and could be used in other places, you know what does it really mean to be the developer or the steward of something like that?

MS. MAINO-FIKE: So do you think that that would be an action item is to look at how we define these customer groups?

MEMBER STOTO: Yes.

MS. MAINO-FIKE: Yes. Maybe we can put that under action items.

CO-CHAIR JARRIS: You know, I think there's almost an infinite number. You know, every grant has measures you have to meet of performance and the part of what drives people nuts is they come up with measures that they pull out of the air, that then change six months into the grant. You know, so it would actually be nice to have some valid reliable measures to assess your performance against.

MS. MAINO-FIKE: Well, isn't that one of the value equations that NQF brings is creating a market, if you will, a desire for an external standard approval where there isn't one now? There is one from a clinical standpoint, but we're saying NQF could be an organization that helps to create that market, that desire in the public health sector. That is a possible benefit to add to the value equation.

MEMBER BIALEK: And it's important for those organizations to have these ever changing, incredibly diverse reporting requirements for pretty much the same thing for them to understand the value in having some consistency. I'm not sure they currently do recognize the value in having that.

MS. MAINO-FIKE: Okay. So NQF could create some consistency and standardization where there wasn't one, and that's a way to lessen the burden.

And, Mike, you had wanted to say

something? Never mind.

Yes, Kurt?

CO-CHAIR STANGE: I really like this idea of focusing on the Community Health Needs Assessment in thinking of the hospitals health care systems as one primary audience. They have this new mandate and then the public health community that's trying to do more with less and realizing they have to convene multi-stakeholder groups. That really is a sweet spot. And if you think of that as the core target audience, you start finding secondary ones that people want to get on board, which would be other government agencies and the business community.

And what made me think of that is the measure that Helen mentioned that's already NCQA endorsed that's really about social role function for children and days missed of school. So if you take that to the working population, I mean that's how you engage the business community with days of

absenteeism or presentism. So that really gets others involved.

And then Paul mentioned anybody who is funding anything wants these outcome measures. I mean, we're making a big pitch in Cleveland to basically all the philanthropic community that they fund all these initiatives, and they under fund the evaluation so they never really know if their money is doing any good. These kind of measures could be something that would be if you made that the baseline that's always being assessed at the neighborhood level and the health care system level in a community, then when they're funding new initiatives and you want to look at what is the impact people being able to go to work, children being able to go to school, health care utilization; if those data are already being collected, then that philanthropic community then doesn't have to put as much of their money into evaluation for every little thing in a way that doesn't

matter if they invest in a way that's on a community level.

So, I think the core constituency are the people who really have to do this Community Health Needs Assessment because then you start bringing lots of other stakeholders.

MS. MAINO-FIKE: Okay. I want to record -- one second. I'm sorry, Matt. Let's record this Community Health Assessment notion. It's been brought up several times as a good maybe first place to start. So maybe we can put that under the proposed next steps. Exploring that, Community Health Assessments, not mandate but action that's already going on.

And, Matt?

MEMBER STOTO: Well, it's a mandate, it's a law. And then furthermore, it's not just a Community Needs Assessment but it's the improvement plans as well.

MS. MAINO-FIKE: Yes.

MEMBER STOTO: It's two separate

mandates.

MS. MAINO-FIKE: Okay.

MEMBER STOTO: This requires different kinds of measures.

MS. MAINO-FIKE: Matt?

MEMBER STIEFEL: Well, to build on that, I think an entire Community Health Needs Assessment would collapse under the weight of the NQF review criteria. Every element of that assessment, that just sounds overwhelming. But perhaps there's some core subset of it. And maybe it's the healthy behaviors, I keep bringing up, that where it's a bite out of it. It's a more tractable subset that NQF could convene, and it could be maybe that group of stakeholders that we talked about of people from public health and people from clinical care delivery measure developers to agree on not the entire thing, but a start, a subset of it.

MS. MAINO-FIKE: Yes. That subset could be the healthy behaviors section. And

one way to address that which would be to get this group of measure developers, both clinical and public, together to look at that.

MEMBER STIEFEL: And the advantage of focusing on that is that is in this intersection sweet spot.

MS. MAINO-FIKE: Right.

MEMBER STIEFEL: The high school graduation it's harder to make the case.

MS. MAINO-FIKE: Right. Well, that goes back to Helen's point of within these concentric circles you know it's easy to make the case that it's a smaller initial concentric circles.

Yes, Amir?

MEMBER QASEEM: So is it also could be NQF's role be just endorsing of the measures as well, like the performance of the performance measures or evaluation of performance measures. And I don't know is not a conflict of an interplay so that if you endorse the measure, that you should even be

evaluating the measures. But I think it's some sort of evaluation in terms of feedback as well whether -- and I don't know if NQF is planning to go that route or not.

DR. BURSTIN: We're doing it in a lot of different ways, not as formal as I'd like. Our new search system, the quality positioning system, the quality measures allows you to give feedback on the measures. We've solicited comments every time a measure that's been endorsed is up for maintenance. We try to do an annual assessment of the overall portfolio of what it's being used for.

And our Usability Task Force this year changed our usability criterion so all projects beginning in the fall have a much -- will need to report on how the measure has proved useful in terms of improvements and also any potential unintended consequences as a result as well. So, we'll start gathering that data as we move forward prospectively.

MEMBER QASEEM: In this case I

think it's going to be extremely useful because as you've said we've already endorsed some of the measures and I know we're talking about how to make it more attractive to get more measures. But maybe we do need to see what we've already done where it get us.

CO-CHAIR JARRIS: I wondered about sort of turning over some rocks such as another place of intersection between the clinical world and the public health world is in vital statistics. And these are hugely unreliable, invalid reams of data being produced that we make national policy decisions on. But it's basically trash.

I mean, if you look at what gets into a death record, you're sitting there seeing 30 patients and they bring you a stack like this of records and plop in front of you to say "Your partner's off today, will you fill out this death certificate?" And you're like flipping through this thing saying "Okay. I'll call it diabetes." Well that's not a

cause of death, but that's what gets in.

So, you know, I don't know if anyone would even want to go there but it's frightening the types of decisions that are made, or who calls in the birth record. It's a clerk who may have some education after high school who is sitting there phoning in or entering into the electronic birth record system the information on the birth.

I mean, so I don't know if we want to turn those rocks over, but it is a really frightening -- I mean if you actually look at the quality of the data, it's horrible.

DR. BURSTIN: And actually, one of our child health/perinatal measure emerged out of California's effort to do just that, to improve the vital stats data. So they worry but to show the reliability of the data on the work that they've done to try to put those data into a better database. So, you know there are options to do that when there are good data available that could be made better

that could be brought to bear for that.

MS. MAINO-FIKE: Well, I see that as another piece of NQF's value equation. If NQF and this group is in a position to standard measures around, you know things like that, it could be another piece of the value equation.

I know you've been trying to say something, Ron. Sorry.

MEMBER BIALEK: I always try to say something.

A comment that Kurt made earlier and something that Matt has said, as well as Paul made me think about another potential stakeholder/customer/funder group which would be the conversion foundations. And that they're struggling with how to invest the dollars that they have to invest in communities to make a difference in terms of health. And they go back to traditional measures, but they really I think some of them, a lot of them, would like to get a

little beyond the traditional but they really don't know how to do that. They don't really have the metrics. And maybe conversion foundations, some of the larger ones or some of them coming together, might be willing to invest in some efforts that really would look at this intersection, develop some measures that they could use for their funding decisions and for their monitoring.

MS. MAINO-FIKE: Right. Good potential partner source.

MEMBER STOTO: And they've got an organization, the National Network of Public Health Institutes. Isn't that them?

MEMBER BIALEK: Not the conversion foundations. A lot of those belong to grant makers and health.

MEMBER STOTO: Okay. That's what I thought that that group was.

MEMBER BIALEK: And NNPHI Institutes.

MEMBER STOTO: Okay.

MEMBER PESTRONK: Quasi-governmental or nonprofit organizations that states or locals create to get their business done or to do work that a governmental entity would have difficulty doing.

MS. MAINO-FIKE: Well let me ask this: What you've got here is a nice list of areas that need to be or could be looked at, strategic objectives to improve the likelihood and data of what you would be getting back from any sort of measures or call.

MEMBER STOTO: Go ahead, Matt.

MS. MAINO-FIKE: Nothing like two Ms.

MEMBER STIEFEL: Just one other thought on the value on the value proposition is this idea of leveraging requirements. That historically, I think that's where NQF's value propositions come from is that NCQA values the NQF endorsement in its role to serve as a measure developer and creditor and all the rest. And the same thing can apply here as

sort of that that's why the Community Needs Health Assessment came is the health care system is being told to do this.

Sarah mentioned the health care organizations are driven by CMS requirements. I mean, that's why we're doing health risk assessments for seniors and that's why we do the HEDIS measures and all, and the Medicare STAR.

So, really I think sort of taking advantage of leverage, leveraging requirements.

MS. MAINO-FIKE: Thank you. Adding those to the notes?

Yes, Michael?

MEMBER STIEFEL: I just want to say that at the top of this thing it says here, you know it says this is all assuming that we're going to issue another call. And it strikes me that after we do all these things we may decide that issuing a call is not the right way to proceed, but that there's

really a different way of working with this kind of community.

MS. MAINO-FIKE: Good point. Well said.

You know for purposes of getting this information we said let's assume that we're going to issue another call. What would we do differently? You know, lessons learned. Knowing what we know, what would we do differently?

So, the decision has not necessarily been made to issue another call.

MEMBER STOTO: My point is that after doing all this work which I think is the right thing to do, we may decide that issuing calls isn't the right way to identify measures to endorse.

MS. MAINO-FIKE: Right.

MEMBER STOTO: That that way of doing business may not be the right way in this new space.

MS. MAINO-FIKE: Right. And so

perhaps another way to reframe this work is to say a potential approach to entering -- I'm just kind of talking off the top of my head here -- to entering into the measures of the --

MEMBER STOTO: Yes. Presuming NQF will eventually want to endorse population health measures --

MS. MAINO-FIKE: Okay.

MEMBER STOTO: -- what do we need to do to get to that point.

DR. BURSTIN: I think we probably just made too many assumptions that the pump was quite primed, and it clearly was not. So I think there's a lot of lessons learned for us about being -- you know before we actually did this again being very clear that there would in fact be measures available. But again, and it may not be totally ready yet, but if you think about if we're doing cardiovascular in 2013, which we will be in the early part of the year, there's some great

opportunities to potentially bring in some population level cardiovascular health metrics to that project.

So, I guess I'd also like this group to help us think through what would we do in a project like that to ensure that some of those really important measures come in at the community level. I mean, we looked at the AHRQ Prevention Community Indicators last year, whatever it was, in the cardiovascular project about hypertension, CAD, issues like that about avoidable hospitalizations in cardiovascular. But, you know maybe there are some other ones. Like I know, you know Peter Briss is looking for a population level blood pressure screening measure for the Million Hearts Campaign. It needs to be done, it needs to be brought in soon. That's something that, obviously, I think you know a Cardiovascular Committee could probably handle if we kind of get some smart folks like you guys potentially at that table. And I'd like

to know what you think we'd need to do to make sure that could happen in a project like that.

That HIV measures would have flown through our infectious disease projects in two weeks, I can tell you that. No problem. It would have gone right through. There would have been great -- like the level of analysis at the community, this is perfect, this is really informative. No one would have blinked.

So, just some thoughts.

MS. MAINO-FIKE: Sarah?

MEMBER SAMPSEL: So kind of in response to that, but also you know this is response to what Paul said earlier about, you know kind of NCQA submitted the BMI measure, you know the same old BMI measure.

I'm just wondering if, you know when we started last fall we looked at the standard NQF criteria and then adapted it, you know tweaked it a little bit for population health. And, you know I wonder if we did kind of a little bit of a disservice to ourselves

by doing that where what we could do is just-- so for this cardiovascular call, you know kind of make it clear that we're not -- you know, we're looking for measures that are translatable at a larger population health level and, you know there's a box they check. This is for a specific subgroup or this could be a population health level measure.

Something like that, they've got people to think they could choose population health? Okay.

DR. BURSTIN: Yes. Our current submission forms clearly allows you to say clinician, health -- and you know for all the behavior health forms we just brought in on schizophrenia, they all just said state. So that's fine, which is why the Committee was like sure these seem like great metrics to do. I'm not sure if I'd feel comfortable with the risk adjustment at my clinical level, but at state Medicaid level those seem great.

So, again, you know that's already

an option.

MEMBER SAMPSEL: But I'm just wondering if it's clear enough that people understand how to translate that when they're submitting?

MS. MAINO-FIKE: It could need some re-emphasizing or clarity around it.

MEMBER PESTRONK: So that is the second of the -- adapting the second of the strategies for use in existing work groups because what we've discovered through this process is that the guidance and the definitions were not helpful enough. They were as good as we could make them at the time, but they weren't good enough. And so if you're going to go back into that blood pressure group, you would want to give that blood pressure group, both the working group and then the customer -- the measure definers or suggesters, you'd have to give them a whole lot more orientation, right?

DR. BURSTIN: Three one-hour

telephone calls with them already, yes. There were.

MEMBER PESTRONK: Yes.

MS. MAINO-FIKE: Okay. Oh. I'm sorry, Kurt?

CO-CHAIR STANGE: So what did we learn from your experience with the Disparities Work Group? And what actions proposed, possibly Helen is getting population and disparities groups together. I think a similar crosscutting strategy for the disparities and for population health to just make that part of all calls or --

DR. BURSTIN: Yes, I mean, it's a very interesting question. I mean much of the work I think we'll do in disparities going forward is in fact stratifying quality measures as opposed to new de novo measures. We brought in measures this time that are more cultural competency, access to language services; things like that. But I think at some point you don't have as many of those

crosscutting disparity measures and you really do focus on the stratification of quality measures. So, we are happy to take those measures in any project when they come in.

Similarly, resource use. You know, I'd rather not necessarily do another cost specific project, but it's easy to see how you might bring in resource use specific measures in a lot of these different areas going forward.

CO-CHAIR STANGE: So that's kind of taking the measure at the current level and stratifying down?

DR. BURSTIN: Yes.

CO-CHAIR STANGE: Is the population health taking the current measure and stratifying up to a clinical population level but then also thinking about a geographic community level and a system level? I mean, is that one way to -- would guidance stratifying down and stratifying up be helpful for the other efforts?

DR. BURSTIN: A rolling up and a rolling down, yes.

MEMBER STIEFEL: Thinking about the call for cardiovascular measures is an extremely interesting potential opportunity. Some of us participated in the NPP group that developed these recommendations to CMS and we came up with that three part frame of interventions at the social, community, economic level. Interventions at the behavioral level. And interventions at the clinical preventive services level. And by the way, that framework was in our call for measures, too. It seemed it was ignored.

But that would be really fascinating to apply to the call for cardiovascular measures to have those three categories of the social, environmental, behavioral and clinical preventive services. It might be a great opportunity to further the population health measures through the cardiovascular measures channel.

CO-CHAIR JARRIS: So if we did this right, every call for measures would include those three levels? And the other thing which we were unable to get -- it got sort of rejected by the overall NPP, is we wanted to create -- some of us wanted to create a goodness and fairness measure so that you have -- this is the 2001 concept from the World Health Organization. Goodness is the overall performance at that population level. Fairness is the difference between the most healthy and least healthy group on that measure in a population. That was rejected as too new of a concept.

We read different stuff, I guess. But I think ideally that would go into every measure to get at health equity. If you're going to put out a cardiovascular measure, you put in the goodness and fairness, okay? What's the rate of MIs among the population and what's the gap between -- I don't know if it's Caucasian and African-American and the

population, whatever the appropriate populations are.

DR. BURSTIN: And we do require that measures that are for maintenance provide back that stratified data. So the Cardiovascular Committee reviewed every single measure stratified by race and ethnicity when the developers had access to it. So all of those CMS core measures were produced, stratified first --

MS. MAINO-FIKE: Excuse me once again.

In goodness, fairness, because I want to make sure we capture this appropriately on those three different levels, which was behavioral I believe was first and clinical and what was the third?

MEMBER STIEFEL: Social and environmental.

MS. MAINO-FIKE: Okay. But we just want to make sure that that's another area where can we -- it parlays into all other

measures.

DR. BURSTIN: So just to answer Paul's question, so essentially the various cardiovascular measures, aspirin use, beta blockers, et cetera, for a measure that was up for maintenance the developers had to submit the data showing, like what you looked at yesterday, essentially NCQA stratified it for you by Medicare, Medicaid commercial and you could see those differences laid out for the NCQA measures yesterday.

CMS has data to be able to in fact pull it out by race. So they were actually able to give the Committee the differences by race and ethnicity, it's 80 percent for whites, it's 70 percent for Hispanics and it was 50 percent for African-Americans. And a couple of times a couple of measures we thought were otherwise topped out, in fact when you dived deep there are some populations who are still at risk. Right, absolutely. Yes.

MEMBER STIEFEL: It has all kinds of interesting I think positive attributes. It makes the case much more clearly about the relevance of the upstream determinants. As opposed to talking in general about population health, we're talking about, you know, very specifically cardiovascular disease. And it may engage people in a different way, and especially if you call for measures in those three categories.

CO-CHAIR JARRIS: That's also why we got to get away from -- okay, renal disease, you know, was whatever a specific test done on patient's renal disease by this doctor as the measure and go to what is the incident or prevalence of renal disease and then break that out by racial and ethnic groups to demonstrate the huge difference with hypertension between African-American renal disease and Caucasian American. But if all you're doing is measuring the did you prescribe a ACE inhibitor or whatever, you're

never going to get at that gap in the population.

CO-CHAIR STANGE: Helen, what are you doing with multi-morbidity?

DR. BURSTIN: It's a tough one. We actually just put out a framework just in the last few months, actually. We should share it with SCRIP. I think they did a nice job with it. Hopkins helped write a background paper for us on how to approach patients with multi-chronic conditions, and it was a lot of getting at some of these big picture issues and also just thinking differently about the sort of single focus diseases and how you might look at that population more in terms of function and health rather than disease by disease.

CO-CHAIR STANGE: So that's a ripe population for it?

DR. BURSTIN: Yes.

CO-CHAIR JARRIS: It occurs to me, it came up earlier is you know, the approach--

the multi-chronic disease approach. The simplest way to do that is to say multi-chronic disease, that means you have multi-chronic diseases so we'll treat this person as three diseases. Well, does that actually create wellness in a person if you treat their three diseases?

And the same thing happens here. If you look at a population, is it simply treating the rates or quality of diseases in that population or is the health of a population something more than a collection of diseases? And that's where we start to get into that concept of well-being in the population health group. But I think that well-being is not diseases, and that's where we miss on all of these.

MS. MAINO-FIKE: I'm going to do--

CO-CHAIR STANGE: The multiple chronic conditions is a fertile ground for making that point. The reason we kind of resisted it as a Committee I think this idea

of just doing it a disease a time is exactly that concern, but that this is a way that you could normalize the population health focus with the disease focus. I mean, multiple chronic conditions has an incredible amount of legs right now. So that would be a way of getting the broader whole person focus and then population --

CO-CHAIR JARRIS: And unfortunately population health was considered outside the scope of that work at HHS. It was clinical. There was a paper put out, an initiative by HHS on multiple chronic diseases and we got very early copies and tried to work with them, and they kept insisting, "No, I'm sorry, population health and public health are outside the scope of this. This is clinical." And it was a huge missed opportunity.

MEMBER STOTO: I think that kind of thinking that the population health is clinical and it's separate is a big problem. But, you know it's common and it runs all the

way through these.

MS. MAINO-FIKE: Do we have that up here as the whole notion of providing clarity on definitions that we're using? Is that up here somewhere? Because I think that's another action item that would be important in soliciting or making any calls for measures.

MEMBER PESTRONK: In the framework that I had it was part of number two. It was part refining guidance and definitions.

MS. MAINO-FIKE: Okay. Good. Good.

You know, I'm going to do a time check right now. As it stands, I think we've done a good job of discussing what are some of the things that need to change that we could do better in sending out a call for measures? Any call for measures, really. It's a fairly broad list.

In terms of wrapping things up, what might be useful we talked about is looking at this list and putting together

perhaps some chronology of what might need to be done. Some of these items may be able to be done together. But what you want to do at the end of the day is this group has the funding for a couple of more months, if I'm correct. Helen, I'm going to double check with you. So how do you want to use your time? How do you want to use that time? And it may be you can take some action against some of the things on this list.

DR. BURSTIN: Some of this is just, you know in our current project. But I think a lot of what we've talked about is what would future initiatives be both specific in this area as well as potentially thinking about how to build this into another projects going forward.

MS. MAINO-FIKE: Yes. Do you feel -any thoughts on how you want to use your time as a group over the next couple of months? What are your thoughts there? I'm going to kind of ask the Steering Committee for their

thoughts as well.

Okay. You're going to let Matt go first?

MEMBER STIEFEL: One idea, maybe, would be to review the compilation of measures and maybe start with a subset of measures, but you know to do the side-by-side kind of evaluation not calling for measures, just reviewing the existing set of measures to see where the overlaps and discrepancies are. That could be a very useful contribution.

CO-CHAIR JARRIS: I wonder as part of that if some of the measures had potential to be turned into population health measures, whether any feedback could go to those measure developers to say have you thought about this?

MS. JACOBSON: This is Dawn.

Can I make one comment in reference to the background paper?

MS. MAINO-FIKE: Certainly.

CO-CHAIR JARRIS: Go ahead.

MS. JACOBSON: Okay. And this goes

back to the low-hanging fruit question, or need to identify that.

We didn't get a chance to talk about this a lot on our previous call, but in December what I did is I took what I considered the 26 kind of go-to indicator sets from health care and public health and I did go through and find the common low-hanging measures. And those are in Tables 2 and 3, sort of by domain and then overall.

And just by default, the Committee comes up with a lot of them that are on there. I know that you talk a lot about infant mortality and prenatal care, you know, tobacco obviously is on there and all of the behaviors that are common on the table.

But in addition to those tables which, you know that is a qualitative assessment and it was sort of a research approach, and we can talk more about the methods if you want to going forward as to how I got those lists. But then on page 35 as

well, and I don't know if you have the whole report there, we did a synthesis table were we took the low-hanging fruit, the measures that are very, very commonly measured from both clinical care system and then sort of the government indicator HealthyPeople type reports and put them next to a column that said who would then potentially lead interventions or health improvement activities for those measures.

And so examples are like hospitalizations for cardiovascular disease, timeliness of diagnosis and treatment for cancer within the clinical care realm. Exposure to secondhand smoke in the physical environment, just more a public health sort of, they take on interventions as leaders.

So I just want to say that some of that work has been done, it might just be revisiting and talking more about the methods that led to the table to really be comfortable with seeing that it's some of the low-hanging

fruit.

And then the other second comment I would really like to make is we put a recommendation in our paper to use existing indicator sets. So a lot of what's being discussed today was part of the Federal Advisory Committee for HealthyPeople, was part of what IOM discussions that lead to the indicator reports. It was the same sort of partners that come to the table and talk about that.

So I just would like to put out there is the leading health indicators, they have valid data sets. You know it's been thought through before. So rather than recreating the wheel, I'm just wondering if there's a way to keep what already exists that have been put through a prioritization level?

MS. MAINO-FIKE: Matt, did you have something you wanted to add to that?

MEMBER STIEFEL: I just think it's a great idea. I think as a starting point, I

think there could be additional work to go to the next level of review of reviewing the measure specifications. This is still just a kind of side-by-side, but the devil's in the details with these. But it would be a great place to start from, I agree.

MS. MAINO-FIKE: Okay.

CO-CHAIR JARRIS: So for illustrative purposes it might be helpful to take the three levels that came out of NPP and take the given measures and put them at the level they're at, which would clearly show us, you know one of these -- that there's very few at those higher levels, but just to point out. And then to maybe take some of them and say "Here would be the potential with this cardiovascular measure to go to these next two levels." That sounds like a great project for a --

MS. MAINO-FIKE: So let's write that down as our next step for a person. I think that's another option for a next step.

I know we have until 2:30. What I'd like to end with is take that time to come up with ideas for what you think those next steps could and should be. Again, another way to say that is how this group might use the rest of its time as a group and make some suggestions. Assuming, you know, we don't have to go until 2:30 if people don't -- if we're all out of ideas. But we have up until that point to decide how you want to use your time for the next several months.

So what else do we have to add to that list?

DR. BURSTIN: One suggestion might be, it might be interesting for us to share a couple of calls for measures that are going out shortly in other areas, like infectious diseases and see if there's a way to sort of write that to make sure some of this flavor comes through. And we template those. We add the clinical stuff in, but they're fairly templated. It might just be an opportunity

for us to think about how to take the influence of this group to spread it more broadly.

MS. KHAN: That sounds like a good idea. I would add that to another future activity. Yes. So take the lessons learned here on other calls that are going out.

Yes. Ron?

MEMBER BIALEK: I would like for us to think a little bit more about how we can integrate the consensus, HHS consensus document or the Quality Aims for Public Health into what it is that we're requesting measure developers to be thinking about and reporting on.

I don't have a real clear idea in my mind, but I think those quality aims do line up fairly well with the health care quality aims and, you know is there some way for us to think about their use in this process?

MS. MAINO-FIKE: Okay. So another

good next step, quality aims integrated with requests for measures.

CO-CHAIR JARRIS: We share other calls for measures also. As I understand it included perhaps development of template language around population health to be inserted into other measures, other quality measures.

MS. MAINO-FIKE: Yes. Right. Thank you. Good point. All right.

What other ideas do you have for how this Committee could use its time over the next couple of months?

CO-CHAIR JARRIS: I would like to hear from the Health Disparities Work Group and compare notes with them. Because they must be having similar issues.

MS. MAINO-FIKE: Okay.

CO-CHAIR JARRIS: Most of what effects health as far as outside of the four walls, it's not just a matter of street to cath time for different populations.

MS. MAINO-FIKE: Right. So hear from the Health Disparities Work Group? Good. What their challenges are, how they're approaching them? Okay.

What else might you want to do with your time?

CO-CHAIR STANGE: Is there a similar opportunity with the multiple chronic conditions group?

DR. BURSTIN: It's done.

CO-CHAIR STANGE: Okay.

MS. MAINO-FIKE: So with the multiple chronic conditions group, what do you think, Helen?

DR. BURSTIN: The Committee's done. They've finished their work, the final product is done. We could share the work if you want to talk to the Chairs or something, I'm sure we'd be happy to get that pulled together for you.

MS. MAINO-FIKE: Okay.

CO-CHAIR JARRIS: What about

others folks working in this area, like CMMI, hearing from them, what they're struggling with. And there may be other -- I mean NCQA looking at this area? Is IHI looking in this area? Anybody else looking at population health and where are they stuck?

MEMBER PESTRONK: AHRQ is looking at it through their own lens. NIH is looking at it, you know, through their own lens.

DR. BURSTIN: NIH has done a very nice convening activity this last year on healthy behaviors that should be put into primary care practices routinely. That work was really nicely done.

MS. MAINO-FIKE: So the action item there would be --

CO-CHAIR JARRIS: You know, as I understand it, and I understand very little about NQF's structure, but the NPP assists with the partnership division of NQF. So maybe that would be a forum to maybe convene, if we get funding for them to convene these

different stakeholders for a day and spend a day of that group on population health measures. We could report out and these other groups report out. And then there are a lot of mostly health care people there, but a lot of different organizations that could discuss this.

MS. MAINO-FIKE: Right. Convene those two groups and maybe have some information sharing, you know report outs might be something that you could do. Yes.

CO-CHAIR JARRIS: Report back to the NPP since the first work in NQF I think was done there about, okay, here's what we ran into so you can be aware of what's going on in this area. And if that process is doing something.

DR. BURSTIN: And we all work very collaboratively, something we could do with NPP with Carrie and Wendy.

MS. MAINO-FIKE: Well, I see this as something you could call -- you probably do

this with all of your working groups, but you know a lessons learned after you've completed your task, that then you share with other work groups regardless of what their topic was because there may be a lot of overlap. So maybe it's formalizing a lessons learned session.

CO-CHAIR JARRIS: I also wonder if we have different mechanism then the work group or the Committee here. And one of the ideas from the morning was doing this environmental scan. We've already done a little bit of an internal scan. But not just to do that to get something you can put in a white paper and plot in front of a group, but doing that as an interactive field relationship building process. And if that's something you'd have to configure more sexily and non-fractally, but that's something you could actually get funding to do.

I mean, how do you make population health measurement a part of what NQF does on

multiple levels? How do you bring together these strange bedfellows that actually have some common needs that they don't have a forum for talking with? If you just thought about a roving bee going out gathering information, but that's asking the right questions and saying you should talk to this group. And then something would emerge from that.

Shouldn't we ask Dawn if she did that?

Dawn, if you're still there, did you do a project -- because some of your question, I thought it was RAND on reaching out to different stakeholders about population health measures to try to describe what was out there? Are you aware of that or was that you that did that?

MS. JACOBSON: No. That was not me.

CO-CHAIR JARRIS: Thanks.

MS. JACOBSON: And I think Nicki Lurie did that before she left.

MS. MAINO-FIKE: Yes. So there's that opportunity to put together an environmental scan and gather those folks together.

Anything else that you can think of you want to put down as options for how you use the rest of your time together?

I feel like Carol Burnett "I'm so glad we had this time together."

How do you want to use the rest of it, not that this isn't a good list already?

CO-CHAIR JARRIS: But what do we do with this list?

MS. MAINO-FIKE: Well, I think the point of creating it is to give the Steering Committee and the Board an opportunity to decide okay, you know let's prioritize, let's see what we have the funding for.

DR. BURSTIN: It's been a really rich discussion. I personally have taken -- what did I take? Twenty -- what is it 22 pages of notes. So, I sort of feel like it's

something we need to process, go through all this, see if we can coordinate it a bit. I tend to think while I type. So if I type it, I learn it and think about it.

So, you know I think we need to process it, think it, bring back some options to you, talk with HHS, see what options are moving forward.

You know, I think there were some great suggestions today of things that I think I'd like to move on, at least. But I think there are some really potential things that I think no one would argue are logically things where NQF could add value.

MEMBER STIEFEL: What's the timing for the call for cardiovascular measures?

DR. BURSTIN: I don't even know yet. 2013, so it's months and months. It's a fair amount away. Infectious Disease was just put forward. GI/GU is going out shortly. So, you know most of the other clinical projects will start in the fall.

MEMBER STIEFEL: Because I don't know if it's listed up there, but one of the things we could do is to kind of create the language for the population health view of all the upcoming calls for measures.

DR. BURSTIN: That's what I was suggesting.

MS. MAINO-FIKE: Okay. Good.

So what you have done today is, as Helen you said, have a very rich discussion regarding what are some of the reasons that the response was lower than you would like for the call for measures. But more broadly, what are some future steps, actions that could be taken to further this discussion around standards and measures in the population or public sector and what might NQF's role be and should and could be in that.

You also took a look at -- what was three? What some of the measures should be, there was some further discussion around that and what the parameters are.

And after, it was almost like you needed to have that thorough discussion yesterday and today and get all the ideas and perspectives out, which I think enabled you then to have more of a concrete conversation, that fishbone exercise around what are some -- we ended up with four or five. I guess we ended up with four specific strategies to not just improve what we would do differently for any future measures call, but for any call for measures that NQF would put together.

And against those five strategic areas, we delved into a little more detail against kind of that environmental scan of who is in the environment that we might want to consider as partners.

You've also delved into a little more detail around NQF value propositions and how to phrase that for your current constituents as well as some new constituents that you're looking at taking on.

And then finally you came up with

a list of potential next steps or action steps that this group could take in the time that it has left together.

So, I think that's a pretty good job. I applaud all of you. Next steps, as Helen said, was to kind of digest all of that information and decide where you want to go with it, particularly those potential next steps for this group.

One thing you will be receiving is a list of this, future activities as well as the five key strategic areas. You'll receive a copy of that.

I think you'll receive a copy of the minutes or the notes as well, is that right? Okay. All right.

With that, I am going to ask Elisa where you want to go with the program as far as the agenda for the rest of the day. We've worked pretty hard so far.

MS. MUNTHALI: We have. And I know we have a hard stop at 3:00 because folks are

trying to get out and take flights.

So the next agenda item that we have was to revisit the recommendations from the Commission Paper. And will put Amir on the spot, because he is the Committee member. I did warn you, though, that I was going to put you on the spot. And he was the Committee member that suggested that we place this on the agenda. And if you don't have a pressing need to revisit --

MEMBER QASEEM: These recommendations, some of them were very good. But I felt like, I think, maybe this is an opportunity for NQF to adopt some of them if you feel like some of them are important. Especially I think Kurt was talking about this as well. And I mentioned it a little bit at how we're measuring this population health and total population health. And I haven't looked at these recommendations for a while, but there was a recommendation in there about systems or as well as how to look at the total

population health. I wish I had -- I don't know which one I'm talking about. But essentially conceptually I do think that we should look at these.

There are some recommendations that may actually be missing from this, which I think would have been part of it. And I don't know how the group feels about them.

And then of course, if we do decide to adopt some of these recommendations, may ned to be rephrased because they're not really -- I don't know how to even interpret some of them. So that's essentially what my point was.

And I will quickly look at it, there was a specific point I was -- okay. Number 2 and number 3. So that was the ones.

Since the determinants of health are conceptually envisioned at the total population level, it is recommended that in a measurement framework we find that when determinants of health at the total population

as well. The current categorization of clinical care, behavior, social environment, physical environment should be used by organizations interested in improving total population health. And that was sort of a concept that I was talking about this morning as well that, you know the performance measures are at a lot of different levels, structured process blah, blah, blah. And I think we really need to start looking at all of them together rather than separate because I still feel like that's what the folks out there are doing. And just because you're going to improve process is not going to lead to the improvement of total population health.

That's it.

Sorry, guys. I have to leave. And thank you so much to see you all.

DR. BURSTIN: It may be an exercise that people would like, we could just share those recommendations probably and ask people to submit comments as to whether there

are ones that they think should be specifically adopted as sort of more oomph than just being in a Commission Paper.

MEMBER QASEEM: Because my fear is that this paper is otherwise going to get lost because it's just -- you know it's an NQF Commission Paper, but if NQF adopts some of the recommendations, it's going to carry much more weight than just --

DR. BURSTIN: And we will be putting out a phase 2 report, of course, with the measures that you have reviewed this round. So we will have the opportunity to include anything you'd like in there about the process, what we've learned. I mean, I think it would be nice to actually share some of the discussion from today potentially as well, and then you think if there are some of these that you would like to include there as well, we can put that out for comment.

MEMBER BIALEK: Helen, do Committees ever submit recommendations to the

Board requesting that the Board adopt them?

DR. BURSTIN: Yes. So frequently Steering Committees will make a series of recommendations about a given topical area of what should happen moving forward. And those will move forward and CSAC usually discusses them first. And then if it's something that has policy implications, it will go the Board.

MEMBER PESTRONK: Is the Commission Paper a public document? Is it available to be distributed broadly, you know, to our own constituencies and to others?

DR. BURSTIN: I'm going to defer to Elisa on that one.

MS. MUNTHALI: Sorry.

DR. BURSTIN: That's okay. What's the status of the public availability of the final Commission Paper?

MS. MUNTHALI: Actually, it's done. We should be posting it Monday probably. So we have the final product.

MEMBER PESTRONK: Could you email

us all a copy?

MS. MUNTHALI: Yes, we will. We will email it to you.

MEMBER PESTRONK: And so then at that point we're free to share it and encourage people to read it?

MS. MUNTHALI: Yes.

MEMBER PESTRONK: Okay.

CO-CHAIR JARRIS: Anything else we should discuss?

MS. MUNTHALI: Just one thing. We just want to give an opportunity to our members and to the public to provide comment, which we're sorry we didn't do before.

Anika?

OPERATOR: At this time I'd like to remind everyone in order to ask a question, press star, then the number one on your telephone key pad.

At this time there are no questions.

MEMBER PESTRONK: So may I thank

the Co-Chairs. Talk about thankless work. Done with fine spirit. Thank you very much.

Thank you to the staff as well.

MS. MUNTHALI: And just a few last minute items before we leave.

Staff is going to follow-up with developers, and that would be Legacy.

I just wanted to remind everyone that the Steering Committee recommended four measures for endorsement. So those will go through the consensus development process.

And we will follow-up with Legacy, work with Ron to make sure that we can get some responses to the concerns that you have, and we'll make sure that we get back to you with that.

As Helen mentioned, we're going to be drafting the technical report for phase 2. And we hope to post that report for our member and public comment on June 21st, and that will be a 30 day comment period.

And before we do that we'll make

sure that you see the report so that you have a few days to give us feedback.

And then we hope to have a conference call to adjudicate the comments during the week of July 30th. We'll confirm that. We send our Survey Monkey with probably three tentative dates and ask you to select from that.

And the report will include your recommendations and the discussion that you had yesterday and today, the evaluation ratings and the measures that you didn't recommend with the rationale, and the measure specifications for all of the measures.

So, we just wanted to thank you as staff, and the Co-Chairs as well. This has been a great meeting for us and we really appreciate the time that you've taken to be with us. Thank you very much.

CO-CHAIR JARRIS: And thank you, Elisa and Kristin and of course Helen for all the work that you put into this. I don't

think we're always an easy group to handle, but you got us here.

DR. BURSTIN: Thank you to Lorraine.

(Whereupon, the above-entitled 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

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter