NATIONAL QUALITY FORUM
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POPULATION HEALTH & PREVENTION ENDORSEMENT
MAINTENANCE STEERING COMMITTEE
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TUESDAY
SEPTEMBER 13, 2011

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The Steering Committee met at the Marriott Wardman Park Hotel, 2660 Woodley Park Road, N.W., Washington, D.C., at 8:39 a.m., Paul Jarris and Kurt Stange, Co-Chairs, presiding.

PRESENT:

PAUL JARRIS, MD, MBA, Co-Chair
KURT STANGE, MD, PhD, Co-Chair
RON BIALEK, MPP, Public Health Foundation
LARRY COHEN, MSW, Prevention Institute
LINDA KINSINGER, MD, MPH, National Center for Health Promotion and Disease Prevention
FRANK LEONE, MD, MS, Penn Lung Center, University of Pennsylvania
SARAH LINDE-FEUCHT, MD, Health Resources and Services Administration
KEITH MASON, MS, National Forum for Heart Disease and Stroke Prevention
RHONDA MEDOWS, MD, UnitedHealthcare
JACQUELINE MERRILL, RN, MPH, DNSc
MADELINE NAEGLE, PhD, FAAN, APRN, BC, New York University College of Nursing
ROBERT PESTRONK, MPH, National Association of County and City Health Officials
SUE PICKENS, MEd, Parkland Health and Hospital Systems

PRESENT(Cont'd):
SARAH SAMPSEL, MPH, WellPoint
JASON SPANGLER, MD, MPH, Partnership for Prevention
MATT STIEFEL, MPA, Kaiser Permanente
MICHAEL STOTO, PhD, Georgetown University
ANDREW WEBBER, National Business Coalition on Health

NQF STAFF:

HELEN BURSTIN, MD, MPH
KAREN ADAMS, PhD
HEIDI BOSSLEY, MSN, MBA
KRISTIN CHANDLER, MPH
ANN HAMMERSMITH, JD
NICOLE McELVEEN, MPH
ELISA MUNTHALI, MPH
ROBYN Y. NISHIMI, PhD
KAREN PACE, PhD, RN
MARY PITTMAN, DrPH
REVA WINKLER, MD, MPH

ALSO PRESENT:

KEZIAH COOK, Acumen

MEGAN LINDLEY, CDC
DAWN JACOBSON, Los Angeles Department of Public Health
ELIZABETH MADIGAN, Case Western Reserve University
STEVE TEUTSCH, Los Angeles Department of Public Health

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

8:39 a.m.

DR. JARRIS: Good morning, everyone, and now is the most important part the meeting, go ahead.

DR. WINKLER: Anthony, are you on the line?

OPERATOR: Yes, we have the line connected.

DR. WINKLER: Please connect, open our lines please. We're getting started. Thank you.

DR. JARRIS: We have a script to follow here. Good morning and thanks for coming from all over. Probably the furthest person to come is Mr. Cohen from South Africa, dodging lions. Right. I think this an exciting initiative that we're beginning here.

It's going to be both conceptually and methodologically challenging, I believe, as we sort of stretch into the area of population health, and it's a great group of

folks in the room. So I'm looking forward to joining you all in this journey.

Why don't we begin by introductions? I'm Paul Jarris. I'm the Executive Director of the Association of State and Territorial Health Officials, which we represent the 50 state, D.C. and the U.S. Territories and freely-associated states' public health agencies and departments. We're based here in Washington, D.C., and it's a pleasure to be here.

DR. BURSTIN: Actually, before we proceed any further, as we're doing disclosures, good morning, I'm Helen Burstin, perhaps we can also introductions with disclosures would be more efficient. So maybe if Ann Hammersmith could just briefly describe what she'd like you to do. She's our general counsel.

DR. JARRIS: Good.

MS. HAMMERSMITH: Good morning, everyone. For those of you who've been to our

meetings before, this portion of the meeting is familiar to you, but I will go over it. Several weeks ago you should have received a disclosure of interest form from us, where we asked you very specific questions, and we then reviewed your responses.

What we'd like to do here today is have you go around the table and disclose anything that you think is relevant to your service on this Committee. I want to emphasize it's not necessary for you to summarize your CV. We just want you to disclose things that are particularly relevant to your service on the Committee, and that may well be nothing at all.

We'd like you to pay particular attention to relevant research or grant monies that you have, that you've had in the last two years, and also to consulting, including speaking fees, which you've had in the last two years, and anything else that you think as well is relevant.

I also want to remind you that you serve on this Committee as an individual, not as a representative of your employer or of anyone who nominated you to serve on the Committee. You are serving as an expert. So with that, go back to Dr. Jarris, and have him disclose, and then if you just go around the room, introduce yourselves and do your disclosure at the same time.

DR. JARRIS: Okay. So our organization is a 501(c)(3). We get substantial funding from Health and Human Services, largely from Center for Disease Control and other branches of HHS. I don't perceive of any of those in particular as a conflict here, but thank you. Dr. Stange.

DR. STANGE: Hi, I'm Kurt Stange. I'm a family physician and public health and internal medicine position from Cleveland, on the faculty of Case Western Reserve University. I also work at a federally qualified community health center, have

hospital privileges at our three health care systems, the Cleveland Clinic, Metro Health, our county system. Is that more detailed than you want for this -- okay.

I have a bunch of grants from the NIH and a few foundations, and am doing three quarter time for the next year with the National Cancer Institute. That's about it.

DR. WINKLER: Good morning. I'm Reva Winkler. I'm a Senior Director of Performance Measures at NQF. Thank you all very much for being here.

MS. MUNTHALI: Good morning. I'm Elisa Munthali, a Senior Project Manager at NQF. Thank you.

DR. NISHIMI: Good morning, everyone. I'm Robyn Nishimi. I was the former chief operating officer at NQF, but now I'm a consultant to them.

MS. MERRILL: Good morning. I'm Jacqueline Merrill. I'm an associate professor in Nursing and Biomedical

Informatics at Columbia. I don't think I have anything to disclose. I have foundation funding and occasionally small funding from CDC.

DR. KINSINGER: Good morning. I'm Linda Kinsinger. I'm a general internist of preventive medicine physician. I'm the chief of Preventive Medicine for the Veterans Health Administration. I have no financial disclosures to report. I do serve as the VHA liaison to the U.S. Preventative Services Task Force and the Advisory Committee on Immunization Practices.

DR. LINDE-FEUCHT: Good morning, excuse me. I'm Sarah Linde-Feucht. I'm a family physician and the chief public health officer of HRSA. I don't have anything to disclose.

DR. NAEGLE: Good morning. I'm Madeline Naegle. I'm a professor at NYU's College of Nursing. NYU is a private university in the public service. I have some

NIDA funding and a substance abuse education grant. I also serve as the director of our World Health Organization Collaborating Center in Geriatric Nursing Education. No disclosures there.

MR. WEBBER: Good morning. I'm Andy Webber, president and CEO of the National Business Coalition on Health. We're a national association of employer-based health coalitions around the country, focused on the triple aim of better health, better care and lower costs.

I have no financial conflicts. Our group does have a CDC cooperative agreement, and we have some foundation grants that relate to population health improvement at a community level, but I think I'm okay. Thank you.

DR. SPANGLER: I'm Jason Spangler. I'm the chief medical officer of Partnership for Prevention, which is a health policy and research non-profit organization here in D.C.

that focuses on clinical prevention and community prevention.

We also have a cooperative grant with CDC and we get some foundation funding, some funding from pharmaceutical companies as well, but I don't have any financial conflicts to disclose.

MR. PESTRONK: I'm Bobby Pestronk, the Executive Director at the National Association of County and City Health Officials, NACCHO. We are a 501(c)(3) organization located here in Washington, D.C., and we represent the approximately 2,700 local health departments across the country.

NACCHO receives grants from the federal government, predominantly the Department of Health and Human Services. We also receive foundation funding as well. I don't believe I have any conflicts to disclose.

DR. STOTO: Good morning, everyone. I'm Mike Stoto. I'm a professor of

Health Systems Administration and Population Health at Georgetown University. Most of my research is funded by CDC, some in partnership with state and local health departments, and a little bit of foundation work as well. But I don't think I have anything to disclose.

MR. STIEFEL: Hi. I'm Matt Stiefel, Senior Director for Care and Service quality at Kaiser Permanente. No financial disclosures. I am a fellow and faculty member with IHI for the Triple Aim Initiative, and serve on a couple of NCQA committees.

DR. PICKENS: Hi. I'm Sue Pickens with -- I'm Director of Population Medicine at Parkland Health and Hospital System, a county -- large health system in Dallas, Texas, and I don't believe I have anything financially to disclose.

MS. SAMPSEL: Good morning. I'm Sarah Sampsel, Health Index Strategies Director with WellPoint. We manage 14 Blue Cross/Blue Shield plans across the country.

Typically, branded by Anthem, and we own Resolution Health, which we will be reviewing one of their measures, and then previously, I was a measure developer at NCQA.

MR. MASON: Hello. My name is Keith Mason. I'm the Executive Director of the National Forum for Heart Disease and Stroke Prevention, a 501(c)(3), in which it's an organization of organizations that care about cardiovascular disease and prevention of that. We are a 501(c)(3) that receives funds from pharma companies, CDC, NHLBI, and AHA, and I have no conflicts myself.

MR. COHEN: Hi everyone. I'm Larry Cohen. I'm Executive Director at the Prevention Institute, and despite what I said earlier about living in South Africa, actually we're in Oakland, California, and I just was in South Africa and feel like I should live there.

You know, our work is entirely on prevention in the first place, ideally before

medical services are necessary. So I hope that's an attribute and not a conflict. But our funding is to do that and to promote that.

MS. HAMMERSMITH: Okay, thank you.

DR. JARRIS: Do you want to introduce yourself? At the end, and disclose any conflicts.

MR. BIALEK: This is Ron Bialek. I do not have any conflicts related to this activity, and sorry for being tardy.

DR. JARRIS: Who do you work for?

MR. BIALEK: I work for the Public Health Foundation, last I checked.

MS. HAMMERSMITH: Okay, thank you everyone for those disclosures. Do any of you have any questions of me, or is there anyone you want to discuss with each other, based on your disclosures?

(No response.)

MS. HAMMERSMITH: Okay, thank you. Have a good meeting.

DR. JARRIS: Helen and the staff,

could you otherwise introduce yourselves?

DR. BURSTIN: Thank you. I'm Helen Burstin. I'm the Senior Vice President for Performance Measures at NQF. I thank you all for being here. Some very familiar faces and some new ones, which is not surprising, considering this is definitely a new area for NQF and we thank you for your patience. It was a bit of blending of minds and culture and we recognize that, and hope you can help us see the path forward. We'll have lots more opportunity to talk, but I'll pass it back to Paul.

DR. JARRIS: Kristin. Kristin, did you want to introduce yourself?

MS. CHANDLER: My name is Kristin Chandler, I am a project analyst at the National Quality Forum.

DR. JARRIS: Okay, thank you. So just a couple of ground rules. The rest rooms are down the hall to my right here. During the presentations, if you want to ask

questions, just raise your hand. If we're having a discussion and you have something that follows on what's been said before, just jump in.

If you want to get into the queue and we're having an active discussion, go ahead and put your card up like this, and we'll recognize you. Paul and I have a list here that we'll develop for running the discussion. Elisa's going to give us our charge and frame for the day.

MS. MUNTHALI: Thank you very much. The Steering Committee has received much of this information during your orientation call and during your work group call. But we thought it was important to repeat some of this, and I also wanted to just highlight a couple of housekeeping things, just to add to what Dr. Stange has just mentioned.

We are recording and transcribing this meeting. So whenever you're speaking,

whether you're providing a comment or a question, we ask that you make sure your microphone is on. The transcript and the recording will be posted to our project page within the next few weeks.

We also just wanted you to know that we have participants on the phone. This is an open call. It's open to NQF members and to our public, who will have opportunity at several points during the agenda to make comments, and we've also invited measure developers, who will be here to add to, to clarify any questions that the Steering Committee may have on their measures.

So Kristin, if you can advance the slide, and we've, I think, all introduced ourselves, so we can go to the next slide. We've outlined several meeting objectives. They include the evaluation of the clinical preventative services and immunization measures for endorsement.

In doing so, if there are any

related and competing measures, we're hoping that the Committee will identify those for further evaluation of measure harmonization, or to select the best measure and class among the competing measures.

We're hoping that in doing so as well, that we identify gaps in performance measures for the measures that are in front of us today.

We're asking also the Committee to provide feedback on the population health annotated outline, and the authors of the outline will be participating by teleconference at about 11:00 a.m. They're in California, so I think they might be still sleeping at this point. But they will be here to answer any questions.

They'll give a brief update and they'll be here to answer questions, detailed questions about the outline. We're also hoping that we'll be able to identify measurement principles for endorsement of

population health measures, and be able to assess how NQF's measure evaluation criteria might apply to population health measures. Finally, we're hoping to identify measures that address healthy behaviors, and this will be part of Phase 2 of the project.

With regards to the meeting format, as I mentioned before, members and the public will have opportunity to provide comment. Our measure developers are here, and what they will do is at the beginning of each measure topic, whether it's the immunization influenza measures, they will give a brief update about three to five minutes. They're here throughout to be available to answer any of the questions that you may have. Then the Steering Committee will discuss and vote on each of the measures that are put before you.

As mentioned before, we are extremely excited about the project, and essentially what we're attempting to do is to expand NQF's portfolio of existing

preventative services and healthy behaviors measures.

In doing so, we're trying to foster harmonization of these types of measures at all levels of analysis, especially at the provider and population level. This project is very unique, in that the Committee will not only consider provider level measures for endorsement, but also population level measures later on in the project in Phase 2.

This work will be carried out in two phases. During the first phase, the Committee will evaluate 19 endorsed and newly-submitted clinical preventative services and immunization measures. Also during Phase 1, the Committee will initiate foundational work to prepare for Phase 2, which we hope will be a consensus development project for provider and population level healthy behaviors measures.

Those measures would include topic areas like smoking, obesity, and physical

activity. Because this evaluation and endorsement of population level measures, as we mentioned before, is relatively new for NQF, there's a great deal that we have to learn, define and standardize.

So in preparing for Phase 2, the Committee will identify measurement principles for endorsement of population health measures. They will also look at our measure evaluation criteria as it might apply to population health, and the Committee will also have significant input into the call for measures for healthy behaviors in Phase 2.

To further lay the foundation for Phase 2, we have selected a contractor, the Los Angeles County Department of Public Health, who will develop a Commission paper to include an environmental scan and gap analysis of population health measures. They will join us later on, as I mentioned, by phone.

I wanted to talk a little bit more about the time line, and this is the same time

line that I shared with you during our orientation call, and I think during the work group meetings. Right now, we're probably, we're nearing the middle of it, and I won't go into detail, but it's included in your slide packet.

Kristin, the next slide. Also to share again, we thought it was important to reiterate the role of steering committees. As you know, the Steering Committee will act as a proxy for NQF multi-stakeholder membership for this project. You will work with us to achieve our goals and that's us as staff.

You evaluate the submitted measures against our measure evaluation criteria. These will be the 19 measures that you're starting off with today. After you've discussed your measures, you're going to make recommendations to NQF's membership for endorsement. During our comment period, which is open to NQF members and to the public, you'll respond to those comments.

Your co-chairs, Paul Jarris and Kurt Stange, will represent you at our project webinar and at our Consensus Standards Approval Committee meeting.

The following outlines the eight steps of the consensus development process, and right now we are on Step No. 3, which is the candidate standards review. So the Committee is going to review, evaluate and recommend for endorsement the 19 measures that are in front of you.

This is just a visual schematic of the CDP, and it shows the important steps again, and the entire process, including the current step, which is highlighted for you. Since this is part of an endorsement maintenance process, we thought it was important to outline the significance of this process.

We recently tightened our endorsement maintenance process for consistency, and to allow our measure

developers, our members and our public sufficient time and notice of upcoming projects. We now have a regular schedule for maintaining endorsement of NQF-endorsed consensus standards, to ensure that these remain current.

Our measures are up for maintenance review every three years. Developers are notified several months in advance of their scheduled maintenance review, and they may opt out of the process. If they choose to do that, their measure will lose NQF-endorsed measurement status. If they proceed with the process, their measure must be reviewed against all of our current evaluation criteria.

During this process, we have accepted new and endorsed measures, and with the increasing number of measures in our current portfolio, and the new measures. We're encountering a number of similar and/or competing measure issues, which may warrant

harmonization of measures, specifications or a determination of which measures is best in class.

So that gives you just a brief update on the project and where we are within the context of our evaluation criteria, and now I wanted to turn into over to Karen Adams from the National Priorities Partnership, who will talk about NPP and the work they've done on population health.

DR. JARRIS: Dr. Medows, would you like to -- welcome, and would you like to introduce yourself, and if you have any conflicts of interest, you have to disburse the money to us and then I'll go on. Go ahead.

DR. MEDOWS: I've missed you, Paul. I'm Rhonda Medows. I'm a family physician. I am the executive vice president and chief medical officer for United Healthcare. I am charged with improving the quality and performance for Medicaid and

Medicare plans, as well as for commercial plans. I don't know how else to describe conflict of interest, other than saying that I work for an insurance company.

DR. JARRIS: There are other guilty parties in the room. You're okay, and others of us who used to. Frank, would you like to introduce yourself, and to let us know if you have any conflicts?

DR. LEONE: Hi everyone. Frank Leone, pulmonologist at the University of Pennsylvania. I direct the Comprehensive Smoking Treatment programs there. I have no conflicts to declare.

DR. JARRIS: Well very good. Just a comment. We'll have a lot of time this afternoon to talk about population health and some of the issues that we have to look at in there. So just, it's helpful for me to keep in mind these NQF meetings. In many ways, these are cross-cultural meetings.

When we bring together folks from

the clinical sector, insurance, public health, we often have different world views, and look at the world differently. So I think it's very important for us all to be patient as we share our concepts with each other, and learn the concepts from the other sectors. By the end of this, we'll all meet somewhere close to the middle, and be a lot smarter for it. But it's going to be quite a process.

So with that, I'd like to introduce Karen Adams, who's the Vice President of the National Priorities for the National Quality Forum, and I've worked extensively with her. A wonderful staff person here and leader.

MR. MASON: I just have one question about Elisa's slides. You said Phase 1 was over in January, but it didn't really say anything about Phase 2. Is that Phase 1 and 2? It just indicated Phase 1 on the time line.

MS. MUNTHALI: Phase 1 actually

isn't over in January. We're hoping it will be over in the spring. Phase 2 we're hoping will be over in the fall, fall 2012.

DR. ADAMS: I appreciate the opportunity to speak with you today, in particular around NPP's work, National Priorities Partnership work. We've just released a report to the Secretary of Health and Human Services on September 1st, so the timing is very important, particularly to this work.

Although we're going to offer kind of an overview of the report, we have played special attention in particular to the population health oriented recommendations, and we certainly welcome your feedback. Allow me to acknowledge that Paul Jarris did serve as our co-chair of the National Priorities Partnership Population Health Subcommittee, and also Jason Spangler and Matt Stiefel, who are on the Committee, contributed to that work group as well. So Matt and Jason, tell us if

we get it right. We welcome your input here as well.

So since, as Paul shared, we have both people who are familiar to NQF processes around the table, as well as those who have been involved with the National Priorities Partnership or other work.

I thought I would spend a few minutes setting some context slides, and then Paul will go into the details around the recommendations, and we'll do a little bit of wrap-up about the next steps and path forward, because certainly this work will be very instrumental in connecting the dots, so to speak, with this national level initiative.

So if you can go to the next slide, please. Just a brief overview on NQF. Of course, many of you are familiar with our long-standing history around endorsement of performance measurement.

But we do have a three-part goal, and about four years ago, our Board did expand

our mission, and you see this here, building consensus on national priorities and goals, and this is the work of the National Priorities Partnership, endorsing our consensus standards, which will be an important role that you'll be playing, and then promoting alignment in the goals through education and outreach programs.

Just a little bit of context-setting around NQF, which is the convener of the National Priority Partnership, and how this plays into our broader mission.

Next slide, please. A little bit about the National Priorities Partnership. Now in your background material, we provided a list of all the organizations, and certainly on our website, we have our contact individuals who serve. But these are organizational representatives.

As I mentioned, the National Priorities Partnership is convened by NQF, and it includes 48 organizations across every

sector of healthcare. I'd like to emphasize here that importantly, when we began our work four years ago, we recognized that we needed additional representation from our colleagues in population and public health.

So Paul, as well as others, have been added to this group, to ensure that we have this broader view of health. You'll see the various other representatives of organizations we have on this Committee, from consumers, through health plans, through industry.

We also have federal partners that you see listed here. We work very closely with Peter Briss at the CDC, as well as others, and our federal partners are ex-officio, non-voting, and this effort is led by Bernie Rosof from the physician consortium, and Helen Darling from the National Business Group on Health. So a little bit about the NPP.

So let me give a little bit of

context, particularly in the realm of health reform and ACA. Within the ACA legislation, HHS must develop a national strategy around this triple aim of better care, affordable care, and importantly, healthy people, healthy communities.

So it was from the beginning, it was very strongly felt that the NQF should be shaped by multi-stakeholder input, that this is a national strategy, certainly a federal type of initiative. But it's a national strategy that requires input across sectors.

So it was very important that there was coordination and alignment around the various stakeholder groups. So HHS requested NQF to convene the NQP, which had already been active for a number of years, to serve in that role, to provide this input from across the different sectors.

So specifically, last fall in October, the National Priorities Partnership provided up front input into the National

Quality Strategy. So we were asked to provide some input around the preliminary framework that was put forth around this three-part aim.

Then, this year, when the National Quality Strategy was released in March, the National Priorities Partnership was asked once again to provide input on the goals and the measures and strategic opportunities.

I'm going to focus a little bit on these strategic opportunities, because there is clearly a role for population and public health, and as will be emphasized, under that bridging of delivery system and the public health, population health sector. So this input was very critical as we moved on. So we will, of course Paul will speak to the goals and the associated measure concepts.

But I do think that the strategic opportunities, as we think about this work, will be critical as well. We just, we submitted our report to the Secretary, 1st September. We're happy to provide a PDF or

copies of the report for you in detail. I know you've got a lot of background materials, so we didn't want to weigh you down too much.

So as we speak to these strategic opportunities, and I'll ask that we go to the next slide please, and then to then to the next slide. Thank you. I'm getting a little ahead of myself. Here are some of the three strategies. So HHS access. Can you map some strategic opportunities to each of these goals?

When the NPP was doing their work, they said you know certainly it would be fortunate to have 32 strategic opportunities or however the number of goals were. But we thought that three really surfaced to the top, as kind of an organizing framework.

One was that we needed a national strategy for data collection, measurement reporting that supports measurement-based improvement. We hear in the field, particularly this kind of a noise and the

cacophony and there needs to be alignment. Alignment is a huge message that certainly came through our public comment period.

So there's both strategic opportunity around a national strategy for data collection, very critical. As we think about that, how do we integrate and population health level data into that data collection strategy will be very critical.

The report goes into much more detail around each one of these strategies. But in regards to time today, I won't go through all those. But you know, certainly the work that you'll be doing now will be very important to this strategy.

The second strategy is around community infrastructure, and this is public and private and that, you know, we need to work with communities. Communities are innovating. It's not so much about telling communities what their goals should be, although certainly we want alignment with the

National Quality Strategy, but now do we help them and support them with the work that they're doing, and building an infrastructure for measurement, public reporting and importantly, a feedback loop for best practices.

So very bidirectional, and we've been working with our community and regional based representatives in this regard. Then the third, which probably will come to no surprise at all, is around payment and delivery system reform, and the importance of primary care. Our report places a lot of attention on upstream prevention, and looking at these different types of integrated delivery models that are under ACA.

As I shared, these are played out further in the report. But we did want to spend a few moments on that, because certainly, your role moving forward, around playing out these recommendations, will be very critical. So Paul, I'm going to turn it

over to you, because of course, this will get into the goals and strategic opportunities, and I'm happy to answer any questions.

DR. JARRIS: Well thank you, Karen, and Matt and Jason, please feel free to help, for we need your help. We made great conceptual breakthroughs during our meeting. Both of them contributed significantly. So overall then, in looking at this, the HHS National Quality Strategy have come out with six national priorities.

There were three, this is based on the triple aim or three-part aim. There were two priorities under what was called community and population health, three priorities under patient experience, quality and care, and another two priorities under affordability, excuse me, one priority under affordability.

For each of those priorities, we have established three goals, and then look at measure concepts and measurement gaps, if we are going to actually establish a consistent

national way of looking at quality improvement across the country.

If you'll look, if you can see that slide, your eyes are better than mine, but on the top of that slide, you can see that there's better care, and then again patient experience, quality of care, and then affordable care on the bottom right, and on the left, healthy people, healthy communities.

Incidentally, during this process, we did not have, that I could determine, a common definition of what we meant by population health, and frankly, in looking back, I haven't found one in IHI or HHS in general. So I think that's something we'll be talking about in our next session.

The priorities established, you can see that six of them in the middle, or perhaps you can't see it, health and well-being, prevention and treatment of the leading causes of mortality, and by that cardiovascular health was chosen, the ABCs,

person and family-centered care, patient safety, effective communication and care coordination and affordable care.

So if we could flip to the next slide. The Healthy People-Communities Subcommittee, there were several themes we came up with that we wanted to make sure then checked back at the end of the process. That was to see if we had stuck with them. We really wanted to promote health and well-being.

So the concept of well-being is introduced, which is gaining further support. We got an email from Target Corporation today and health and well-being of their employees and customers is one of their corporate goals now. But again, going beyond just disease or absence of disease, trying to find out what are the attributes and characteristics of well-being was important to the group.

Health equity was critically important. We find that many of the

publications and documents, wherever they come from, including the HHS ones, certainly mention health equity. But when it gets down to it, there's very little meat on the bones. We wanted to really introduce this as an important concept, and that we will not have a healthy population unless we specifically address health equity.

Recognizing the need for intervention across the life span, Charlie Homer was on the committee. So needless to say, pediatrics was well-represented, and but also just the notion that for CMS, for example, there's little they can do if everyone hits age 65 and enrolls that are very ill, that we really have to look at what factors predispose people towards illness, or in fact the concept of health sustainability would be an interesting concept. How do we keep from breaking people in this nation, and breaking their health?

Incorporating community,

behavioral and clinical concepts. So in other words, broad-based notion of what constitutes health and well-being, not just the physical and clinical health that we often deal with in the health care sector, and emphasizing the importance of composite and outcome measures.

So ideally, we would have composite measures, and we'll talk a little bit more about this later, that you could disaggregate into specific behaviors, if you're looking at what is a measure of healthy behavior, for example. Next slide, please.

So the goals, we set three goals, and I think this actually may be important to this group, and could inform some of the work of this group. Clearly, it appeared to the committee that much of the concept of what was around community and population health was at the clinical level, clinical and preventative services.

In the most limited way of viewing that, you're talking about a population health

as clinical preventative services among my patient population, or it could be my hospital service or my insureds or enrolleds in the insurance company.

So we wanted to recognize there's that strong view held by many people out there, by putting on the bottom, if you look at the third bullet there, receipt of effective clinical preventative services across the life span in clinical and community settings, acknowledging that clinical preventative services are important.

But then to go above that, and I think this is perhaps touched on in what's called Phase 2 of this project. We wanted to look at healthy behaviors, and behaviors we don't simply mean pejoratively, you know, if people only behaved right they would be healthy.

But healthy behaviors means that people live in a context in which it is possible to choose healthy behaviors, and that

those healthy behaviors become the easy and perhaps default behavior.

If you're living in a food desert or if you live in a crime-ridden area, you simply can't get healthy food. You can't afford it or it's not available in your inner city or rural grocery store, and your kid can't walk to school or play on the playground, because it's full of drug dealers.

So again, here the context is how do we create an environment in which healthy behaviors become the easy choice? On the top, the third aspect, goal aspect was community interventions that result in improvement of social, economic and environmental factors, recognizing there are social determinants of health that are very powerful, and that there policy levers, both public and private policy levers that can affect the environments in which people live, which can make the difference between being able to live a healthy life and not.

So we introduced this concept of these three tiers of goals and carried that through, and I think that might be something that's made it through the National Priority Partnership overall. So it is an official NQF, I think we can say position. So therefore, I think again we might want to look at that as we try to conceptualize what we're doing within this group.

Next slide, please. The measure concepts, I think the importance in looking at these is that look at how broad-based they are. Concepts of adequate social support or social capital, connectivity, has a lot to do with resilience. You see that a lot within youth or substance abuse or mental health and other areas. So it is a very important concept to start looking at.

Mental health. We wanted to make sure, and there's a substance abuse measure up here and binge drinking. We wanted to make sure we were looking at other leading causes

of death and disability, and not simply locked into the physical health that we often spend our time with.

ED visits for injuries. We put that in there, because injuries still continue to be one of the major causes of death for people under age 35, and that can be addressed both at individual level in the clinic, unless you live in Florida, which is illegal to ask, if you have a gun. Excuse me, Rhonda, a former Floridian.

But it can certainly be addressed at the behavioral level, in terms of getting people to wear a seat belt, and it can be addressed at a policy level, in Click It or Ticket, or in many other ways.

We thought it was important, in looking at behaviors, to try to come up with some index. Not do you just eat right or you exercise, but what is the composite measure of healthy behaviors, to see how people at a population level, how are they? Are they able

to and do they choose to behave in a healthful manner?

Then dental health made it up here also. Important, because dental health not only is one of the most common chronic illnesses, if you look at it from that point of view, but it certainly affects how children can learn in school, and it affects people's employment and employability. If your teeth are rotten, you can't even work a retail job, and again, back to social determinants. Your median family income is probably one of the major determinants of your health.

Then immunizations, which I think we'll get to today, a very obvious preventative measure at the population level. Next slide, please.

Gaps. Again, there's a lot of measurement gaps, we believe probably in this community and population level, particularly from NQF's perspective, since this is an area they haven't worked on. I think those in

public health perhaps have different types of measures that they look at, but they may or may not fit within the current NQF methodology.

So healthy lifestyle behaviors, again a composite. Community environmental assessment. What does it mean to be a healthy or healthful community that promotes well-being? How do we measure that, and my guess is that we don't really have a good measure right now. We have many measures.

Productivity. This concept was introduced in terms of, you know, if you're talking about well-being, you're probably talking about people's functioning as well. I mean, are kids going to school or are they absent? At people at work and are they productive? There's not absenteeism, presenteeism and other things like that? Are elderly people able to live a full life in their retirement years? These are gaps we think will have to be addressed.

Next slide, please. The second national priority was promoting effective prevention, treatment intervention practices for leading causes of mortality, and HHS specifically wanted to look at this notion of cardiovascular disease as the number one killer in the nation in the disease category.

Again, we applied the goals at the preventative services, behavioral and community level. We can go onto the next slide, and rather than looking at, in this community and population, at the specific disease processes, we were trying to look at the causes, if you will, the underlying causes of these diseases, which would, of course, be tobacco, nutrition, exercise, and alcohol and other things, although we did hit measures in all three levels of the goals here.

Why don't we go on to the next one? So population levels, measurement gaps of some of these clinical things. How do we measure that? I think we might talk more

about that here, as Dr. Stange said. What is the denominator and how do we use that?

The ABCs, we do need good. So aspirin, blood pressure control, cholesterol, and smoking. Do we have good aggregate measures of that at the population level, and then healthy foods. How do we measure whether or not an individual or a community has access to healthy foods in their communities?

There's been a lot of work done on food deserts and all, but I don't think there's an accepted measurement for that. Next slide.

Now we're into the area of patient experience or it's not called that. We call that the quality -- and quality area, and a large emphasis on person- and family-centered care, engaging people in their care as active participants, as knowledge participants who can navigate the system, and also be clearly involved in leading their own care.

I'll let you read through some of

these goals and measures. I won't go through them in the same detail as the prior one, because they're clearly very important, but you can read these on your own, if you will.

Next slide, please. Patient safety. Again, a very important area. HHS has the Partnership for Patients which NQF is working with them on, which is basically a patient safety initiative. I'd encourage you to all look at this.

For those of you across the spectrum, it's another area where there are active discussions with HHS and CMI, Center for Medicaid or Medicaid Innovation, about the role of people outside of the purely clinical sector and patient safety.

It tends to have been launched as a clinical initiative, and they are starting to gain an appreciation that much of the work for patient safety goes on in the public health sector also, all the way from preventing health care-acquired infections to

hospital licensing and on and on.

Next slide, please. Effective communication and care coordination. Certainly, culturally competent communication is important we need to measure and develop goals around, but also the care coordination between levels of care, whether that is hand offs, primary care, specialty care, hospital, long-term care, nursing home, but also the notion here that we need to engage the community and understand how the clinical sector and the community integrate, and how that hand off in care coordination occurs.

Next slide, please. The final group, affordable care. Again, a critical component of everything we do. I'll let you read these here, but some interesting concepts about consumer affordability. I'm sorry, my eyes are failing me and I'm not close to my slides here, so I wish someone closer would read some of these.

Measures trying to limit the

annual percentage of growth in healthcare, as well as the per capita health care costs, you know. Can we compare that from one area to another, and who actually has responsibility for that, and can we set goals and achieve them, which will be the real challenge here.

Next slide. Karen, I think we're back to your area here.

DR. ADAMS: So we thought we might wrap up just with kind of a context-setting, and where this falls in the broader quality picture, the big picture, so to speak, and this slide here represents what we refer to as the functions of the quality enterprise. There's many important contributors and stakeholders to this in the various moving parts, and where do we fit here.

We just, if you look at the first box, we just shared, you know, an important part of a quality enterprise is to establish national priorities and goals. So part of the work of the National Quality Strategy and the

National Priority Partnership feedback into that was one of those critical first steps. You see in the box we focus that around the triple aim of better care, affordable care and healthy people/community.

As we go along this flow, the next box is around identifying measure gaps. Paul highlighted several of the measure gaps that were identified for population health. There are other gaps, particularly as we think about more cross-cutting measures as well. But certainly, one of the roles that you'll be serving is to help us fill some of these measure gaps that are critical for advancing the goals around population health.

Then certainly there's upstream measure development. We're looking at existing measures and how those might be applied. Now, the green box that we also have highlighted is the endorsement process that you're participating in.

I'll go through the other ones

just quickly, but certainly one of the strategies we talked about, we're building data platforms and how do we collect these various data streams, so that we can get a good overall picture of health and public reporting, our next box, and using that for informed choice and selection and decision-making.

We talked about another strategic opportunity around payment and alignment of payment incentives with these various care deliveries, which certainly translates into improvement around quality improvement and performance. We don't want to forget that we need to have an ongoing feedback loop, and that evaluation just isn't at the end, that we have to be -- this has to be built in up front, and certainly to look for any unintended consequences as we think of these measures and they're applied.

So a little bit of context as to where we may fit into this broader quality

arena. Then our next slide we have here, we're starting to refer to this as the cascade, and I noticed that when I reviewed your materials over the weekend, there was some referencing to this cascading, and how do we get this type of shared accountability across all levels of the system.

So if you think at the national level, and we use this as an example for tobacco, and Paul, you talked about different policies too that would come into place as we look at these different levels, and what type of drivers or what type of things would we look at these each levels to advance towards these goals.

This one gives an example around tobacco. It could be played out and it's illustrative, of course. But it could be played out various ways. So, and this really builds on some of the early work of the National Quality Chasm, where they spoke to different levels and the microsystem, and this

is really evolving into the HHS as the National Partnership at the national level. What measures and measure concepts would you want to put forth, to evaluate against the goals that were identified?

But certainly there's a role at the state and community level health plan. I would also add, you know, certainly these emerging areas around ACOs, patient-centered medical homes, other shared saving models. Provider level, you know from hospitals, nursing home, home health, etcetera, and then the individual provider.

We don't want to forget about, of course, the consumer. So you know, in an ideal world this would cascade and roll up and down, and we know that there are many methodological as well as harmonization issues. But as we strive for this shared accountability, this is a concept that's coming forth, this cascading, and we do speak to it in more detail in the report.

It also ties into some work the NQF is doing around the Measure Applications Partnership. HHS has asked us also to convene another partnership, to look at recommending measures and measure steps for payment in public reporting and rulemaking input. So you know, very important to connect the work we're doing at the NPP, at the national level with these various units of analysis.

So Paul, I'll turn it back to you. I think that wraps it up for our background.

DR. JARRIS: Good. Jason or Matt, did you want to add anything, having sat through this process?

MR. STIEFEL: Well perhaps this comment will just foreshadow the discussion that we have later today about the relationship between that work and this work. One thing that jumps out at me is the framing, with the three-part framing of this work, of community, behavioral and clinical.

What appears from the pre-reading

here is a two-part framing, behavioral and clinical and not community. And I'm happy to, you know, defer that to the later conversation, but I think that's something that is important to address.

DR. JARRIS: Jason? Okay. Other comments or questions from the group? Dr. Stange.

DR. STANGE: Just to Matt's comment, I actually have a question for Helen. So this looks like, the work that Karen and Paul presented looks like very helpful background for our work, and we certainly have the chance to have an influence on this analytical framework that the subcontractor is doing.

I'm wondering about the things you're going to present on the measurement evaluation that we received some stuff about. Do we have any influence on this, or is this a done deal?

DR. BURSTIN: That is very, very

drafty. That was literally just our attempt to put something in front of you, as we recognize how difficult it will be to kind of put some square pegs in some round holes. And I also just want to briefly respond to Matt's comment, because I do think as we thought about how to frame this project, the question was can we do all of it at once?

I think, as we've talked with our HHS colleagues, for example, and at least thought it would be helpful in our first foray out into this area, to try to focus on a couple of high priority areas, and chose, for example, at least as the initial starting point, smoking, obesity and exercise, that could we potentially use those three as the way to explore those three levels that emerged from the NPP?

I think our concern was would be boiling the ocean and then just kind of fail? If we couldn't at least try to stick to a set of areas where there is logical overlap

between clinical, behavior and community. So I don't think we meant to exclude community at all. I think we're just trying to wrap it in the context of what's doable, and also a big part of what we do, as we'll talk about going forward, is a lot of what NQF has been working on over the last several years is really harmonization of measures.

We've spent an inordinate amount of time trying to take measures that come from different stewards, that come from different sectors, nursing home, hospital, home health, ambulatory. I mean just the amount of cacophony out there, just on the clinical sector alone, has given us a tremendous amount of work. Reva has gained many gray hairs through cardiovascular project this year alone, as you can imagine how many measures there were to be harmonized.

So I think one of the challenges is going to be is can we at least begin thinking about that framework of harmonizing

a reasonable set of the highest priority areas in those domains. But by no means do we mean to exclude community. But I think it's in the context of those higher priority areas, if that helps Matt.

DR. STANGE: So if I could just follow up on that. So the incremental steps that Elisa talked to us about are really about clinical preventative services in Phase 1, and then the health behaviors in Phase 2. But there is potentially a Phase 3 that's not yet articulated, that's really broader, and then might involve the community and other things.

Our chance to set the frame for that is when we talk about these evaluation criteria and then the analytic framework and principles. Is that --

DR. BURSTIN: You know, that's a good question, Kurt. I guess as we were thinking about it, I'm not sure that we can't do two and three together. So I think in some ways, and Paul isn't going to like this, I

think in some ways we -- and that's part of our challenge here, right?

So some of you will think of some of the community indicators, for example, that may emerge from BRFSS or some of the other indicators projects that many of you have been working on. Isn't there an opportunity there to think about what those healthy behavior measures would look like at clinical, as well as at community?

That's why in fact the smoking measures and the obesity measures were already submitted to us, and we've made the decision that you're not reviewing them in this phase, because there's a critical opportunity, we think, to think about the harmonization as the other more community-oriented indicators flow through. But again, if that's not the right framing, you know, we're certainly open to --

DR. JARRIS: The reason I shake my head is that it's a very common perception that, you know, if people only ate right and

exercised, they'd be healthy. But when I worked in the inner city school, those kids couldn't eat right and they couldn't walk to school. I saw sexual predators, registered sexual predators sitting outside the playground of the school.

So you know, you've just got to recognize there's a context that people live in, and one of our important jobs is to create an environment where people can be healthy, where those poor little kids could grow up and eat and get out to a playground. So Larry.

MR. COHEN: Well, I had a very specific question, but I am going to jump into this instead first, and then ask the specific, which actually relates, based on your comment, Paul.

I think in terms of the notion of cascading, and in terms of the notion of unintended consequences, one of the things I'm very aware of is that when we start from our comfort zone and say well maybe, you know,

there's a limit to what we can accomplish, that one of the potential unintended consequences that the emphasis on the community, which is where most health and maintaining health takes place, tends to be diminished or possibly ignored.

To say we'll get to the community later, we'll fold it into behavior, sets an approach or a context where it really tends to be minimized, you know. I'm fully understanding of the notion of we've got to start with what we're most knowledgeable about, what we're most comfortable with. At the community level, the kinds of indicators that we have are much more difficult to access. It's much more challenging.

Therefore, unless we really emphasize that, we often end up in a situation where the community, in effect, is given second shrift, despite the fact that I think we probably all share the notion that the community is probably the focal point for

maintaining health and wellness, and also for maintaining people who are not healthy, but maintaining their level of injury, illness, disability, etcetera, as opposed to it diminishing.

So that worries me a great deal, and I mentioned that in the orientation. But it really worries me in terms of the structure and strategy here.

The specific question I wanted to ask was -- well, let me say one more thing about that, which is that my notion, from work I've done on prevention over a number of years, is that the fundamental issue is not one particular measure or approach, but it's really community norms change.

So even Paul, when you gave the example before, does the community have access to healthy food, you know, versus being a food desert, the question I would ask is, does the community overall emphasize healthy food? Where is the balance? What is the level of

emphasis, because only by changing norms and changing environments are we going to change from a sick culture to a healthy culture.

That's going even further and it's harder to measure. Admittedly, it's very hard to measure. Therefore, it worries me if we leave it out, because it's hard to measure, and say we'll start with where we're comfortable.

So the initial question I wanted to ask was specifically, when you mentioned safety, which I was very happy you mentioned, whether we're also talking about violence prevention or just unintentional injury. Because for me, violence prevention is not only important in and of itself, but it's a critical trigger in terms of chronic disease, and more importantly perhaps, in terms of your comments a critical trigger in terms of equity issues.

If communities are not safe, then all the other community health factors can't

come into play nearly as well, and we start to have a two-part society, where some communities are safe and others aren't, and so there's a different level of attention. So I mean for me, that would be a high priority issue here, and I'm not sure whether this question applies to what you reported or it applies to later in the conversations that I've just asked about.

DR. JARRIS: Yes, you know, it's a good point Larry, and what -- within the earlier work, advising HHS on the National Quality Strategy, we recognized that injury-accidents what was important, I think we looked ER visits, was the concept measure there. But we didn't specifically get into type of what led to it, although as I'm thinking about it, I wasn't thinking about violent injury. So I don't think we got there.

I have an order here, which I think is the order in which the cards get up.

But if it's not, then it's my own arbitrary order. Bobby, you go next.

MR. PESTRONK: Thanks. I also like the idea of separating out community frame from other frames, so that it does get specific attention.

I wonder, given the fact that the agenda and the process for this group seems to have been established, perhaps a practical solution to identifying what the community could address in the community frame is right now at the early --

While we're in the first steps of this process, why don't we commission a paper that could inform our subsequent conversation about what the community theme and frame means, and ask that that be done by a group or groups that are knowledgeable about this area?

So at the time we come to explore the community frame, we're not asking ourselves what it means. We have the background materials that we might concur

would help inform our discussion. Then, we don't -- we have a running start on it, rather than trying to drag it into the conversation at the last minute.

DR. JARRIS: So part of the challenge, as you underline the question, is you know, there's a charge to this Committee. How fixed is that? Where does it come from? How modifiable, you know, is it, because I think that's what underlying this conversation right now.

DR. BURSTIN: Just one brief response.

MR. COHEN: You know, are the resources that commission further work to inform us on other aspects of this.

DR. BURSTIN: And just to respond, I think if you look at the outline of the commissioned paper that the folks from LA are doing, I believe they actually are attempting to address that. Again, it's just an outline. They're going to be on the call with us today.

I think there is an opportunity. I think they certainly have that knowledge to potentially move in that direction.

I think you just need to take a look at that outline, and see if there's a way to make that work, because that is part of their charge.

DR. STANGE: I'm sorry, if I could just follow up on that. So that was actually the genesis of my question. So what are the outputs that we have, and certainly that commissioned paper is one. What about this measurement criteria that you described? Do we have a way to influence this and what's the mechanism for that?

DR. BURSTIN: Absolutely. You will be doing that today, as a matter of fact, having that discussion, helping us think through. Just to put this in context, and we can do this in a little bit, but we've done this recently when we did resource use measures for the first time. It was very

clear. Some of these just didn't quite fit into our old mind set, Sarah's smiling, of how difficult it is to evaluate those kinds of measures.

So we recognized we needed to go back, offer additional guidance, perhaps give some different terminology that does resonate with the different communities engaged in that part of measurement. So our expectation is we'll need to do the same thing for population health. So that is wide open, Kurt, for your input.

DR. STANGE: So we actually have two mechanisms now. One thing we can do is look to see how adequately we feel those mechanisms have captured the issues, and if not, then we can look at whether we need to recommend other mechanisms perhaps.

MR. BIALEK: I'd like to understand the framework that we're using a little bit better. For instance, if the priorities really are smoking, obesity and

exercise, if one were to construct a logic model and look at what really can impact that. For smoking, for instance, taxation and smoking laws, in terms of secondhand smoke, will impact that far greater than what can be done in the clinic.

For obesity and exercise, similarly, far greater impact can be achieved outside of the clinical setting than in the -- far greater will be achieved in the community, excuse me. So I'm just wondering the framework, because we're starting -- everything seems to be very clinically-based. We're starting with the clinic. We're starting with the clinical intervention, and then we're cascading down to other interventions.

It seems to me that I would like to see laid out, again, where are we achieving the greatest impacts, and then look at measures within those areas of greatest impact that may be clinical or may be population-

based. But I don't think separating it the way that we're doing is necessarily going to get us to where we want to be.

DR. JARRIS: It's a good point, and I think that probably what we're -- the area we should look at is where is the interface between the clinical and the community. Back to the comment of this is a cross-cultural experience, NQF has historically been a clinical measures organization, and now they're inviting public health people to the table. So we've got to start where NQF is, and then try to move NQF or perhaps expand the sphere that they work within.

So I think it could be dangerous for us to go right to community, because there might not be a context in which it's understood. Which is why we came up with the three levels of measures, to say let's start at the clinical and then let's walk toward the others.

But I think it's going to be important, at least from my point of view, that we understand that path includes going toward the community.

MR. BIALEK: Paul, I'm not suggesting we start with community. I'm suggesting we start by looking at what has the greatest impact, and then based on what has the greatest impact, where do we actually have measures. It may be clinical; it may be community. But it just strikes me again, if we're looking at the objectives of improving quality, cost, efficiency, et cetera, that separating the way that we're separating it may be very unnatural.

I understand the perspective, that we really, you know, starting at the clinical may be just a necessary piece. But I think we need to be thinking about where's the greatest impact as we go along.

DR. JARRIS: Could I -- I just want to asking a clarifying, thank you, Ron,

clarifying question. You mentioned that smoking, obesity and exercise were the focus. I didn't see that in the pre-read. Did I just miss that, or where did --

DR. BURSTIN: It's just been some of the discussions we've had with HHS, that we recognize again, we can't do everything, and they thought given that those are among the highest priorities for the Department, and those are the ones we think, going to your point, where there is the greatest interface potentially between some of the measures in the clinical space and some of the measures in the community space, that would be a good place to start.

I'm not sure that's in conflict with the idea of doing a logic model and thinking about where those greatest impacts are, perhaps in those areas.

DR. JARRIS: You know, the top three underlying causes.

DR. BURSTIN: Exactly.

DR. JARRIS: So maybe it makes sense. I think I had Linda next.

DR. KINSINGER: Hi thanks. I wanted to go back to the National Quality Strategy, the report that you mentioned. I've been involved with developing the National Prevention Strategy, also in the ACA, and there hasn't been any discussion of this report there, nor did I hear any really discussion of the Prevention Strategy report here.

So I'm wondering how these two reports are intersecting or if they are, because it doesn't seem to me that they are, and how could they?

DR. ADAMS: So Linda, thank you for raising that, because certainly this speaks to the alignment issue, and I apologize. I really should have emphasized that in my opening remarks, because one of the alignment issues, of course, is working closely with colleagues at HHS, you know, not

only across the various programs, but even within HHS, and then how that also links with private sector initiatives.

So as well as Paul, George Isham, Peter Briss, have been very involved, and very much want to have this synching up an alignment with the National Prevention Strategy. But we also need to think there's lots of strategies coming out. We have the National Prevention Strategy. We have the Partnership for Patients in regards to the safety initiative.

Today, the Million Hearts campaign is going to be launched around the ABCs. So I think there's a critical need here, and we've tried, as we went through this, as you see, the safety goals synching up. I think it's really important that we have this synching and we have this synergy, because these strategies all interconnect and they're not competing strategies.

I'd like to see them as

reinforcing strategies, whereas for example, the Partnership for Patients. You know, clearly the readmissions focus, the hospital-acquired conditions, of course, but being the community is very important as well. You know, how do we fill these population health kind of gap areas as well, and of course the prevention strategy.

I'll also add the SAMHSA framework, which is very much built on the priority areas framework. So I think it's a critical message of the synching and the aligning. Of course, now that the report is released but really more upstream, we'd be happy to work with you in the QuIC -- there's a new name for it.

It used to be the QuIC Two, but the QuIC Group, the quality agency, inter-agency group. There's like -- there's supposed to be like a quality inter-agency group amongst HHS that is looking at some of this. So we're happy to work with that.

MR. COHEN: Would it be appropriate to ask that, in terms of particularly the National Prevention Strategy, which I think is key, to ask that the LA group look at that as part of their work, and really incorporate that in terms of measures?

DR. JARRIS: There's also the National Action Plan to End Health Disparities, which doesn't seem to be integrated. That's a critical one. It should be foundational to every one of the others.

DR. ADAMS: I remember at our first meeting, we had several people come from HHS. Of course, different things were in different stages of development, but to kind of see how up front we might work on that synching, since we're going fast in a parallel track. But thank you for raising that.

DR. JARRIS: Remember?

MS. MERRILL: Do I remember? There's well a number of things I could say. But one, to your point of coordinating. Is

ASPE still in existence, and do they have any interest in creating an overarching framework, and should they be included in these kinds of meetings? Assistant Secretary for Evaluation and Planning at HHS.

DR. JARRIS: It does exist. Sarah, do you know their involvement here? I don't, because I think --

DR. ADAMS: ASPE is our project officer for the -- they're the coordinating link. So Kate Goodrich is our project officer at ASPE, who oversees the contract which this National Priorities Partnership work was under. So ASPE is part of this process.

MS. MERRILL: I hope she's a powerful personality.

DR. BURSTIN: Peggy Honore from the Office of the Secretary has been one of our other links, and I believe she's going to be joining us at some point today.

MS. MERRILL: Good, okay. So the initial thought that I had was this. I'm a

professor at Columbia and so I teach. I teach the medical students three times a year, and I go in. This is a sophisticated group, so you probably know the answer to the question, but they don't.

So I ask them if the health care system is part of the public health system or if the public health system is part of the health care system, and I ask them true or false. That simple framing of the health care system is the major system, is really how they think, and I see that we are -- whether we want to or not, are starting to fall into that way of thinking, and it's deeply inculcated.

So I think that that's something that we need to be aware of, that simple true or false when we're thinking about things. So it is -- the health care is part of the public health system. That is really where we are. So that kind of speaks to your concerns.

Then there's another point. I'm trying to weave together a lot of disparate

threads, is this idea that you got the call from Target. I'm just thinking well, the corporate culture in this country does drive decisions at community level, how money is spent, how actually municipalities actually spend money to respond to decisions that are made at the corporate level, in terms of waste packaging, salts, all kinds of things.

So that's another part of the puzzle that we're dealing with then. I'm also thinking that perhaps representatives from that community, it would not be a bad idea to include some kind of corporate representation, because corporate culture really does rule. When you're talking about root causes, they're right there.

DR. JARRIS: Very interesting. Andrew, Andy?

MR. WEBBER: Bobby actually took my comment, and I just want to endorse doing some early work on the community framing. You know, I think we have a fabulous opportunity

to bring worlds together here through this Committee, and I don't want to lose that opportunity.

But I think some early work on the community framing, I think was a good consensus of that's where a lot of the gaps in the thinking reside right now, particularly as it relates to the history of NQF. So I think that would be an important early signal.

I think part of that, Helen, looking at sort of the measure development enterprise, if you will, is to do some early work on identification of measure gaps in terms of community conditions for health, would be important, as part of that work.

And let me, you know, I think I'm the only representative of the business community here. So let me say, in terms of a response to the last comment, that you know, mea culpa, in terms of the business community's impact, both negative.

But I think we also need to think

of the leverage of the business community, and their ability to impact all the conditions for better health. I think the best way to approach the business community is not to lead with, you know, "you create unhealthy products and stressful work environments," but to talk about the fact that the business community, when they look at the goal of health and productivity as a business imperative for them, we've got an opportunity to really engage the business community in very useful ways.

So I think that's another part of, I hope, the bringing together of different parts. The wonderful thing about NQF, and why I've spent so much time -- I sit on the board of NQF, by the way -- is that it's a wonderful representation of partnership capability and different stakeholders coming together.

So I just want to again say that the key to partnerships is finding common denominators among all the key stakeholders.

I think all the stakeholders have a lot more in common, in terms of the goal of population health than we have, you know, what divides us, of which there are many issues, I will recognize. So anyway, just --

DR. JARRIS: You know, I think there's also some real leadership. If you look at, for example, Target doesn't sell cigarettes. They've made that determination. Walmart is now the second or third largest organic grocer in the country.

(Off mic comments.)

DR. JARRIS: Largest, bringing organic foods to poor people who shop. I mean they have made, they have a huge footprint, in terms of doing good things in our community. So I think we, I agree. We should welcome them in.

I'm curious, Frank and Sue, I don't know a lot about your procedure, coming from a clinical orientation, and I'd like to hear your thoughts about this. Is this

resonating? Does this make sense? Is it like are you looking at it and saying what are these crazy people talking about?

(Laughter.)

DR. LEONE: Well, there's a little of that. No, I mean I'm actually learning quite a bit. So there's some ideas that have been floating around that I hadn't really thought too much about, that have been crystallized for me this morning, so I appreciate that.

It's true, that I feel like the health care system is sort of the 800 pound gorilla in the room. It's the machine that just keeps moving forward and it sort of sucks all the other perspectives out, the oxygen out of all the other perspectives. I think that it's good to look around the table and see all the various perspectives, trying to keep that in check.

I actually sort of agree. I sort of heard the words "community perspective,"

"community frame" thrown around. I'm having trouble understanding exactly what that means. I think it would be a good idea if we -- well, if somebody could educate me over lunch, that would be great. But otherwise, if we could maybe sit down and just sort of come up with some standard definitions of what the community frame really means that might be a good idea.

I would encourage the group to sort of think outside the box. We have a lot of information that's already pre-existing about what works, what doesn't work, what the relative impacts are of different things. But this, I feel like this group represents an opportunity to take systems that may be broken, and maybe not previously as effective as they could be, and try and stimulate some change in systems, to make them even more effective than they've been in the past.

So I'm pleased to be part of this discussion, and it is definitely resonating

for me, Paul.

DR. PICKENS: Well, I definitely, like Frank, have learned a ton this morning already, and I represent a very large public health system working in community, where if we have a community, a healthy community, we make money, because they don't come to us. They don't have to be in the hospital.

I've spent my last 18 years trying to work and figure out how to measure what that is, as well as what kind of interventions work, both from the clinical into the community and back and forth. I've looked forward to participating in the discussion, and trying to help figure this out.

DR. JARRIS: And similarly Matt, you sort of walk two worlds there with Kaiser Permanente. So you may be one who can help us bridge some of this. Any other comments? Anyone we didn't hear from who would like to take a chance to speak?

DR. BURSTIN: I have a question.

It's actually interesting, because I think that if you look at the framing of the LA Department Public Health folks' outline, and they'll be on when it's almost morning on the West Coast with us, is I think they mainly framed it, trying to understand the clinical care system and more the public health system as their frame.

I think one thing that might be helpful as they come, you know, before they come I think actually would be useful for us, Paul and Kurt, to actually spend a little bit of time trying to do some definitional work, make sure we're all on the same page. Because I'm not sure everybody's using the community frame in the same way or public health in the same way or health care system in the same way. I think it's actually a worthy exercise.

DR. JARRIS: I am sure they're not.

DR. BURSTIN: I know. We ought to do it.

DR. JARRIS: Michael.

DR. STOTO: I was going to save this for when they get on the line. But I think the relevant point here is that in the clinical world, we spend a lot of time thinking about accountability as associated with these measures.

The focus, I think, of the LA paper, is on the shared responsibility for health outcomes, and they actually kind of, I think, shy away from the accountability of health departments and other organizations in the community, from actually doing something.

I think that's what we have to work on, is how do we look at, you know, holding different organizations, not just clinical, but all these other organizations, and not just health departments, but all the other organizations including companies and so on, accountable for what they contribute to the overall outcome.

DR. JARRIS: This is a critically

important point Mike's bringing up, and it's something we really probably need to spend some time on. I think actually Andy, NQF as a whole needs to spend some time on this. It really is one of those grass is greener type pictures, because I know there's a couple of people here who have been appointed officials in government, and the fact that you can get fired in an instant for a story in the newspaper, or that you may or may not have had anything to do with, is a real level of accountability.

The fact that you are sued multiple times per week for things that are going on, because you're a figurehead is a level of accountability. I basically went for an umbrella policy recently, had to list all the lawsuits. Diana Bonta from California had a lien put on her home and couldn't sell it, because of a lawsuit against her in her official capacity.

So there are levels of

accountability that are scary when you step into the public sector, and often, and we hear this, and I came from the clinical sector. When you hear from people in the clinical sector saying well, how are any of those people held accountable? I think they are, and I'd love to hear from the Targets and the Walmarts. Why is Walmart selling organics? There's somebody on Wall Street holding them accountable for their product line at some level.

So this conversation of accountability is going to be a very important one. But I would say that we have to move beyond what I've heard now for a couple of years at NQF, is that well, you know, those public health people, this is pretty close to a quote. Nobody knows what they do and nobody knows how to hold them accountable.

That's a view from somebody outside of the field, not from somebody in the field. Rhonda, you're shaking your head. I

don't know how many lawsuits you have still hanging around you from Georgia.

DR. MEDOWS: Enough to keep my grandchildren busy for many, many, many years.

DR. JARRIS: It was three and a half years before my final lawsuit in a professional and personal capacity was dismissed after I left an appointed position in government. So there's real accountability.

DR. STOTO: So in the clinical quality area, I think long ago we moved away from this idea about finding out the bad apples, and to kind of measuring overall performance of systems. It strikes me what you're describing about public health is the old way, and we need to find a way to kind of measure performance in a kind of statistical way, that's parallel to the health care provider system.

DR. JARRIS: Right, we do. Tomorrow, at the National Press Club, there

will be an announcement of the formal unrolling of the Public Health Accreditation Board, to accredit state and local public health agencies. There hasn't been a process before. We've been working on it for five years now.

So at least we can put that criticism aside, in terms of certification of the competence of departments.

MS. MERRILL: Earlier in the year, there was the IOM Report on Measurement. We have a reference in that as well? Is that coming into this discussion? Because I didn't see that mentioned. You know what I'm talking about?

DR. BURSTIN: Yes, and actually Dawn was one of the -- Dawn and Steve were one of the authors of one of the chapters of that report. So they'll be bringing that in as well.

MS. MERRILL: Okay, good.

DR. STANGE: I'm particularly

anxious that we're not just having a nice conversation that will look at the action steps, and I've really heard two action steps. One's the commissioned papers. So if we want to affect that, I think we should save our comments from when the people are on the line. Otherwise, we'll feel good about it, and it won't appear in the output.

The other action steps that I've heard is the quality measurement criteria that Helen's going to talk to us about, and Helen's in the room. So I'd like to suggest that we focus our efforts on that, and think about how are we going to affect that, what's the feedback loop for us, what's likely to happen with that.

But I also would like to make sure that we save some time, before we go on to the more mundane work, of going through the existing measures, that we say okay, do we have, are we satisfied with where we are for the next steps, or doing it to suggest

something else?

But I think the next steps, since Helen's in the room, is to look at the measure evaluation criteria, that are the drafting of measurement criteria.

DR. JARRIS: Very good, but Larry first.

MR. COHEN: I mean I feel like there's some kind of action step about reconsidering the agenda and strategy to bring community in much earlier, and in a much more consistent and significant way. I feel like that's the implication of a lot of what people have been saying.

I don't know exactly how the action step gets translated, whether it's by the staff or how. But I definitely don't think that that was just idle conversation.

DR. STANGE: So Larry, that's what I'm actually trying to do. I'm suggesting we have two steps on the table right now. One is Helen's work here with the measures; one is

the commissioned paper. I think after we've done that, I think we have to re-ask your question, is that enough.

MR. COHEN: Okay.

DR. JARRIS: Rhonda, a final comment.

DR. MEDOWS: I was going to say can I just second that motion, and then we vote, what Larry just suggested?

DR. JARRIS: So what Larry's suggesting, to paraphrase that I've got it right, is that we actually look seriously, if you will, the goal or charge of this group, so that it does include community as one of the measurement points, and that we start looking at that early on, and preparing, as Bobby suggested, before we get there.

Now I don't know if that requires a vote, or if there's a consensus. Is there anybody here who strongly feels that that's not an approach we should take? Silence means assent.

MR. COHEN: Yes. I just feel like it's not based on your comments, Kurt, and I want to just acknowledge I have very little understanding of exactly how this process works, and it's fairly new to me. But I wasn't clear of what the implications would be, in terms of, for example, our work over the next two days.

To me, it says that our work over the next two days should look somewhat different than the current agenda, and that the way in which we approach things and the kinds of conversations we have, and the kinds of questions we answer around what do we mean by community, what do we mean by a definition of population health, which in terms of what you were saying, Jacqueline, that you know, many people see the medical first, that I was actually very surprised very recently frankly, to learn that population health often was about people with a medical condition, rather than about the overarching population.

I think that really getting into some of those issues, the implications of those issues in terms of looking at things like the National Prevention Strategy, as central to the way we think, and not just as oh, we'll get to that eventually. That may, as I say, be totally implicit in what you were saying, and I just didn't understand it.

But that's why I suggested it's a very clear action step, and requires some transition in the work we do here over the next couple of days.

MS. MERRILL: Just in that definition of community, we want to bring in the business work life aspect of it. It definitely has to be --

DR. BURSTIN: Let me just try to respond to Larry. I think we heard you loud and clear. I think the way the day has been set up is in fact all just discussion of these exact issues, in terms of what the scope of the paper should look like. You're going to

have the chance to talk to Dawn and Steve shortly. They completely get this. This is not alien to them at all, for those of you who know them.

You'll have a chance. We've got a several hour block this afternoon. We're going to have just community, just discussion among the Committee about what is population health, what are we really talking about here? So I think we have the opportunity to influence, as Kurt said, the framing of that paper, which is commissioned, and they're going to be doing that work. We can kind of move them to make sure it fits the needs of the Committee as it's emerging.

I think also, as Kurt mentioned, these evaluation criteria are wide open. You can really say, you know, this really works for a very clinically-oriented measure. It would never work for these kinds of measures. I think we'll kind of get closer to what we're talking about.

I would still find it useful, and maybe that's more something we'll get to, after the discussion with Steve and Dawn, to actually do some definitional work, because I think it probably help us all, to make sure we're all on the same page. But I think that, you know, all of that will be useful.

We do, as a matter of course, just need to, because some of these measures are getting quite old. We need to look at those clinical preventive services and immunization measures. That's part of our process.

We thought it would be useful to actually look at some measures that are the more traditional ones, as we then think about how we're going to kind of shift over to the more community-oriented measures in population health.

So I think we're saying the same thing. I think we can get there.

DR. JARRIS: Yeah, I think so too, and Rhonda, I'd ask you, you know, since you

asked to vote. I think we hear enough consensus here to move forward.

We were charged by NQF, among other things, to look at these measures, and I think we should do our housework, as asked. Also the benefit to that is that will allow us to look at how NQF goes through their processes. So as we stretch into new areas, we at least understand where we're coming from.

So I mean I agree. It would be unsatisfying if that's all we did and left. But if we can do that, re-look at the scope of what we're doing, and then start from the basis of how NQF approaches things, and again try to move into new areas, I think then we'll really have done a service. Bobby, this is the final last comment.

MR. PESTRONK: Yes. This is just a very -- and this is a very quick one. It seems to me that somewhere here a picture would be helpful to orient us to our approach,

and it might help us both the logic behind the approach that we're taking, and give us a way to focus on what we think the most important sets of measures around population health would be.

It might suggest to us in a different way than trying to pore through a lot of pros, what's most important and what's least important, and give others who are trying to understand the work that we're doing, easy access to the approach that we are taking.

DR. JARRIS: So Helen, I believe our next step is to move to you for measure evaluation for population health measures, and we're six minutes over, so we're doing pretty well.

DR. BURSTIN: Great. Thanks, everybody. So here's your chance to see where we've been, and help us think about where we go.

So NQF traditionally, the measures

we have endorsed to date, have primarily been measures that affect various sectors of the health care system, with clear accountability to those providers, individual clinicians, health systems, and again, in some ways as we've been thinking about a lot of the movement towards ACOs, I think it's going to be very similar kinds of issues about denominators and populations that I think will continue to be important, even beyond this context of community as well.

So what we thought would be helpful is actually to walk through the current NQF evaluation criteria, and you have that packet. It's Attachment 4 in your folder, or sent to you electronically as well. So we thought it would be useful to actually go through each element of our evaluation criteria, and see the applicability of those criteria for measures at population levels, including the community.

NQF always uses the same criteria

for all of our projects generally. As I mentioned, we've modified them slightly for certain projects like resource use, and we think we're going to do the same thing for an area like population health.

But, you know, essentially the four cornerstones remain the same. Importance to measure and report, which I think gets to the issues Bobby and others brought up about trying to think about what are those most important areas we absolutely want to take care of and address; the evidence base as being really critical for the measures; scientific acceptability of the measurement properties, i.e., are they reliable, are they valid, are the specifications precise? Is it usable and is it feasible.

So those four cornerstones, I would argue, probably still work, and I think the issue is really definitional and adding the guidance to make this work. So let's just walk through this. Yes, Kurt.

DR. STANGE: So in the things we were given in the opening memo, that those criteria are actually prefaced by saying NQF's existing measure evaluation criteria appear to be appropriately specified for population performance measurement.

I think what we're hearing from the discussion is that assumption might not be true. So I think these are good criteria. I think there is, what we're hearing is let's think of what that means for community. Let's think about what that means when you actually specify denominator, and that actually might turn out that these are good but not sufficient.

DR. BURSTIN: I think what we're saying there is just a very general framing, those broad concepts of importance, evidence, the reliability of the measures, the fact that they're usable and feasible in whichever context you're talking about, we think, would still logically apply.

There's a whole lot of words associated with that that could change dramatically when you're talking about a community context versus clinical context, I think.

MR. PESTRONK: Are we open to science from other places?

DR. BURSTIN: Absolutely.

MR. PESTRONK: Because the science and the conceptual frames that orient science are different in different countries and in different cultures. The Canadians, for example, have reached, have historically taken an entirely different approach to how they orient their both public health and medical care system, and their approach to having a healthy population.

For some reason, that orientation doesn't take place. That kind of orientation doesn't happen here, and I'm wondering whether that has something to do with how we accept evidence, or whether -- well, so the question

is what are we open, what is NQF open to, and what is NQF historically open to, and is that another door that needs to be opened?

DR. JARRIS: I suppose those Canadians just don't know how to make money.

(Laughter.)

I'm sorry. The other issue is even -- the sciences of public health are not the same as the sciences of clinical medicine and bench science. So that's the other issue we're going to have to look at is -- and I've had that discussion in some of the IOM committees about, you know, are observational studies science or not?

Well, if you're dealing at the level of a population, they may be the best you have.

DR. BURSTIN: And actually, I think as you'll see, as we walk through each of the criteria, every single one of these issues is going to come up. We're going to come up to it as soon as we get to the

importance criterion. So do you want to hold or go or --

DR. STOTO: Well, I guess I have a thought that there may be something important that's not in those four. But maybe it comes in under importance, and that's the question about who's accountable, following what I was saying before.

So I think that implicit in all the standard NQF measures is that the health care system is responsible for doing this for the patients, and I think that in the population health realm, it's not quite clear who is responsible for doing various things, and sorting that out may be important.

DR. JARRIS: So how is it that only somewhere between 40 and 50 percent of people with diagnosed hypertension are controlled? Who's accountable? If you take five diabetic parameters, 20 to 25 percent of the diabetics have them controlled. Who's accountable?

So that's my issue with that. I mean, what does accountability mean if our care is so bad?

DR. STOTO: Well, that's the question that I think the measures have to address. I mean, I think that any health plan would say, well, we're not accountable for those people who aren't in our plan. Sometimes they'll say we're not accountable for the ones who don't come to see us. And so on. But you know, the community may feel a responsibility for getting that to happen, and then you can say, well, who's going to do something about that?

Well, it may be that someone needs to do some screening, or it may be that someone needs to do some education, or it may be that somebody else needs to do something else about that, or it may be that the facilities aren't there for doing the testing; someone needs to provide that. Or it may be that health, the employers may need to say

that's part of the package that we buy, that that be done.

So you can imagine that different entities in the community have different things they could do to reach that goal, and I think that part of what we need is how to sort that out.

DR. BURSTIN: We've tried to actually weave that through, as you'll see here. Oftentimes, the criteria would have said "organizations or providers," and we've just said the accountable entity or entities. I mean, I think that's going to be one of the issues, and I think increasingly, if you look at the measures we've been trying to move towards like, for example, readmission measures, there is a movement towards trying to move towards measures that reflect shared accountability.

I think what we're really trying to get at is: where is that shared locus of the high priority areas where we could share

that responsibility, and I think it will oftentimes be more than one accountable entity. Did you want to say something?

DR. NAEGLE: Yes, I just wanted to comment, because Mike led us to a way of thinking that really hasn't been reflected in our framework, even though it is inherent, and that is the whole notion of the cultural norms of the community, and I don't mean culture in a very narrow way, ethnicity or race.

It's how are things done within our community around health? That determines so many responses to what we consider are larger system initiatives all across this country. I do think that you're right, that Canada identifies that more clearly, in looking at their approach to evidence-based practice, where the consumer has much more to say about what he or she wants to pay for, what he or she prefers as a mode of treatment.

So as we're thinking about community, I want to be sure that we get all

those normative factors somewhere in our assessment process looking at measures.

DR. STANGE: I'd like to suggest that this is actually one of our lever points. The NQF has given us their draft evaluation criteria, and I think we need to budget our time. My understanding is that Helen's going to go through this chunk by chunk.

Let's budget our time so we get through each chunk, and get the major comments down, because I think with some of the specifics here, we can really start to move the needle. Then we do want to come back to these general comments, after this and the next session, to say what's not there.

But so, Helen, how about if you go through these chunks, and let's feel free to say you know, these are good comments. Let's have some people to write them down and send them to you, so at least we get to discuss all the aspects.

DR. BURSTIN: And I believe Nicole

and Elisa are up there in fact to capture those comments, that will return to our parking lot. So thank you, ladies. So okay, it's on the screen. I must admit, I must need new contact lenses or that's unreadable.

But you do have this. The exact thing we're working off of is in your packet. It's called Attachment 4, the NQF Measure Evaluation Criteria. Let's just walk through it.

So the first thing is that we have a set of conditions for consideration. Before we'll even look at the measures, there are several conditions that are always met. I don't personally, I mean these, I think, would be similar. We want to make sure that a measure's in the public domain or a steward agreement's been signed.

We need a responsible entity to maintain these measures. Part of what we try to do is the science changes; somebody's got to update these measures, bring them back to

us every three years, which is why you're going to get to look at some of these other measures coming up.

C there is an interesting one, and I think it's one we may need to spend a little bit of time on, which is that the intended use of the measure is both for public reporting and those other accountability applications like pay for performance or accreditation, as well as quality improvement. So we've recognized there are many, many measures that have been used in the QI space only. They work beautifully in that space.

But if they're not rising to the level of actually being used to compare or provide, you know, used for accountability, we have not traditionally brought them into the NQF portfolio. So I think that's one thing. You may just want to think about how that plays in the context. Yes.

DR. STANGE: So just on this chunk, I'd like to suggest as a general thing

that could be looked at throughout. So it says -- the "both/and" is really good. But the idea that it might not be the same measure that's used for both/and. So there might be some measures that need to be different.

Then in (b), where it says "clinical intervention," wherever there's clinical it should be a serious look at what needs to be in the right column. So there could be community and population health interventions.

With the both/and idea under (e), in the right column it says "Provider level versus population level." So I think what we're hearing here it's probably provider, community and population level, and not versus. But probably that's a both/and among those three domains.

I think that's one of the ideas we're hearing here. Yes, the provider level's good, the population level. But the population level is more than the aggregation

of those clinical measures. So thinking about provider, community and population is something to -- is a way to reframe it.

DR. JARRIS: I also think that what do we mean by harmonization, because it shouldn't mean that in my practice, everyone has an A1C of less than seven, in my hospital service area, in my community, and that's what it means to line up. That's going to state two clinical differences.

There may be, for example, in tobacco, there may be a measure of at the provider level, of how many people are identified as smokers and counseled. At the behavioral level, how many people access quit lines, and at the community level, are there clean indoor air laws, what are the tobacco taxes, and things like that.

So those are harmonized, but they're not the same measure added up and down the system.

DR. BURSTIN: And that's actually

not what we are intending. Truly, it's harmonization, and some of this really comes down to harmonization, and some of this reflects the science issues that have been brought up. So if there's one consensus way of measuring smoking, would it be useful to have the community surveys match in some ways?

I think there are opportunities there to make sure that we in fact are all offering off that same, you know, reading off that same hymnal of saying -- funny thing for me to say -- but, you know, being able to actually understand that we're talking about the same thing.

DR. JARRIS: So one is a matter of scale. Can you take an individual measure on the scale to the population, and the other is really harmonization. Are these complementary measures, designed to achieve the same end?

DR. BURSTIN: Exactly, and avoiding when there's competing, which is what we often encounter. So you may get -- it's

also not helpful if there are two standardized measures that may be using those different levels, but give you a very different message, if you're the provider in that community, versus thinking of yourself as a community provider.

So I think we're just trying to -- I mean, I think there's a lot more to do here, and this is probably a good area to come back to, as we try to further explore that framing of what's community. Did you have a comment back there, Bobby?

MR. BIALEK: Well, since we were talking about E, just an observation. It strikes me that the harmonization piece requires the population measure to not compete and to be harmonized with all of these other types of measures that are clinical, as well as community we just spoke of.

But when I look at the clinical measure, that harmonization of the population and community measure is not a requirement.

So it just strikes me that the burden, if you will, on the population measure is far greater.

DR. BURSTIN: And that's not our intent. Our intent is in fact that the clinical measure should have the equivalent burden, and in fact, the harmonization goes both ways. That's really the intent of this discussion.

MR. BIALEK: Okay. So then, would the wording in that left column change as well, since you added wording in the right column, requiring that harmonization?

DR. BURSTIN: Potentially. NQF does re-look at its overall evaluation criteria on an annual basis, and I think part of what we've been seeing is we've gone into these newer areas. We've emerged with newer guidance, and at times I think some of that newer guidance needs to get built into the overall criteria for NQF, as these become more mainstream. Yes, exactly. That's exactly,

I think, where we are. That's very helpful framing.

DR. JARRIS: Larry.

MR. COHEN: Again, forgive me if I don't fully understand how the process works. But it seems to me that harmonization is between the clinical measures and the community measures. But there's another element, which is the measurement of inequities. I'm not sure whether that's a separate piece, or whether that gets included here, how to incorporate it.

But I think -- oh, it's here already? Oh, okay.

DR. BURSTIN: All right. So we're going to keep moving, and actually I would jump us ahead to the very first real set of -- the first criteria. The rest of this is sort of more boilerplate.

Let's go to number one there, sort of the middle of page two, which is actually our -- this is a must-pass criterion for NQF,

which is importance to measure and report. Importance to measure and report has three elements to it.

The first is that it's high impact. The second is that there's a performance gap, and the third is that there's an evidence base for the measure focus. So we'll go through each of them in detail. But that's the broad framing of this.

We don't evaluate measures further. We actually don't care if they're reliable, usable or feasible if they're not important. So this is the must-pass. In our hierarchy, we then look at the science of the measure, in terms of reliability and validity, and if that is not there, we also stop. So those are our two stop points.

But importance is probably, I think, the most important framing for us today, as it relates to the discussion we've had before. So in the overall discussion up top here, we specifically said improving

health care quality and outcomes. The question was, should we add population to that or community, and see if you think the draft language that's in here is helpful.

Then there was this question that keeps coming up about accountability, and we thought, since it's been brought up a couple of times, that it would be useful to put that in here. Again, these are just straw men, language for you to react to. Paul's got his pen out, so please let us know.

DR. JARRIS: You know, I'm looking across from one in Column B there, and it's again very health-care-oriented. Importance to making significant gains in health care quality, and improving health care outcomes of a specific population, by which that means to me like a diabetic or hypertensive, for a specific high-impact aspect of health care, where there's variations.

This is all still purely aimed at health care, it seems. So we really again

have to -- if in fact we're looking at population health, then we need to introduce that concept.

DR. BURSTIN: Right, and specific population here was not intended to be diabetic or anything like that. It was supposed to be literally getting at a community. That was not the intent of at least our draft language here.

DR. JARRIS: Because it also could, it could mean by specific population, my population as a hospital or as a doctor or as an insurer. So we have to really be clear what we mean.

DR. STANGE: The other thing that Paul's getting at is health care quality. There are other aspects of quality. So there's, we have a community guide, and we have public health community preventive services. So there could be quality that's in both, more than health care.

MS. MERRILL: There's this problem

with this word "population." It's creating so much difficulty everywhere. People are so confused about it, everywhere I go. So you're saying here a specific population, but you mean a community, a defined community.

DR. JARRIS: Even the word "community" is one of those meaningless words, so.

DR. STOTO: I think that what we need to do is be specific about what we mean, and understand that it could mean different things in different contexts, that traditionally in NQF work, it's referred to as a group of people who are part of a plan or see a doctor in a given year. But in population health work, it could be people who live in a certain place, or I can imagine it being defined another ways.

But it's important just to be specific about what we mean by it in any given setting.

DR. JARRIS: Maybe we can -- let's

park this up there, because when we talked to the LA group again, they attempted some definitions. Let's see if what they came up with is good enough. But I have a feeling this is going to be something we're going to keep going back at, and hopefully we'll get right.

DR. STANGE: Well, this is something that will need more work. So Robert suggested earlier the idea of a logic model. So when you're talking about impact, the impact here is beyond health care quality. So the impact has to start looking at population measures of health.

You can define that as the whole country, a state, a community. You can define that in different ways. But it's raising the gaze from the health care of the individual to other determinants of health for groups of people.

MS. MERRILL: So maybe that's all it needs.

DR. STANGE: So we're not going to solve this here, but this is where a logic model about how would you measure an impact for, and what does quality look like at the population and community level for the things that we can measure and the things that we can then intervene on, that meet your other four criteria, that have an effect on health at that group level?

Then that's going to beg the denominator question of how do you define the group.

MS. MERRILL: So would it help just to say, I mean, that word "specific." Instead of saying specific, just say for a defined population group.

DR. STOTO: Maybe just define population.

DR. STANGE: Helen, what we're going to do here is we're going to get a sense from the group discussion. Will there be a chance for people to send things, and then

there'll be an aggregation of this? This is going to take multiple iterations. We're not going to be able to wordsmith this here, this group. Is that the process we're engaged in?

DR. BURSTIN: Absolutely, and that was part of the logic. Again, I don't want people to feel like we're sort of putting community second. I don't think we were ready to ask for community measures right now, because I think we need to get this straightened out first.

So that was the idea of doing the foundational work, while we kind of do our more traditional kind of measurement. Think through these issues, and then be able to call for measures and actually be able to evaluate them in the second phase, or else I wouldn't know how to evaluate these measures.

DR. JARRIS: Now there's one aspect of this that we're way ahead of everybody else. Is that, as we've already called into question, what we don't know?

Because how many groups have you been on where they just keep using the word population and community, all talking about different things, and nobody says we're all talking about different things. So at least we flagged it at the beginning.

There's one other thing across from 1). The notion of specific accountable entity, because you know, it's going to be hard in population health. It may have to be entities. For example, an accountable care organization is an entity made up of an insurer, providers, hospitals, all kinds of other things.

There are also like through some of the new ACA initiatives, Communities Putting Prevention to Work, which is actually before ACA, where it's a consortium that's held accountable, sometimes led by the political leadership, sometimes by clinical, sometimes -- in Iowa it's led by the business leadership.

But some entity has to say okay, we're going to be held accountable for that and achieve it. But it's not likely to be one legal incorporated entity. Matt, and then Bobby after that.

MR. STIEFEL: That was going to be my point as well, but just to elaborate a bit. Watching the evolution of IHI's Triple Aim initiative, it started with a hodgepodge of organizations, some governmental, some insurers, some providers.

Almost in all cases, in order to achieve the Triple Aim, these groups realized that it required the efforts of a multi-stakeholder collaboration, to achieve population health especially.

So they've all moved in the direction of, some very explicitly, in a multi-stakeholder coalition. So I think it's important enough. While you could say the specific accountability entity is the multi-stakeholder coalition, that doesn't lead you

necessarily to that. I mean, it's so important in population health that it's worth specifying.

DR. BURSTIN: How would you specify it differently, Matt? I'd just be curious as to your thoughts.

MR. STIEFEL: The notion of shared accountability among different stakeholder groups is a notion here that I think is so critical for population health improvement. That's a very different concept than the language here, of a specific accountability entity.

MR. BIALEK: Well, on the last point, I think it's both/and rather than either/or. Shared accountability doesn't mean that nobody's accountable. At least that's the frame that I have in my head. Shared accountability and a partnership model can lay out within that partnership and that collaborative approach, who's got responsibility within their own domains for

doing specific things.

The successful partnerships, the ones that actually produce better health outcomes, do that. They don't just say let's go -- they say first of all, and that's -- we do an assessment in our community, and we understand something about the status, health status, life status, quality of life status of people in our community, and we recognize -- we not only have what our status is, but we're able to contrast it with some other community, to say there's a difference here, and that difference leads to conversations about there shouldn't be that difference and we'd like to do something about that.

Everybody goes around the table and says, well, okay, yes, that's right. So there's the first consensus.

MR. PESTRONK: First step.

MR. BIALEK: The second step is to say okay, now they have that difference, what are we going to do about that? And everybody

says okay, that's right. So there's a look around the table and everybody holds hands through a very difficult process, and they say here's what I'm going to do.

If you've got a real quality improvement process, you don't get stuck on trying to do the best thing first. You just get started and establish a process where you're constantly contrasting differences over time, recognizing whether those differences are shrinking or not.

So it's a both/and process. It's shared, and there are specifics within it. The reason -- specific obligations within it, and it works. The reason why I raised my placard before is to make suggestions to the chairs and to the staff.

Because of the way the agenda has been framed, to look at what are clinical, preventive, and I emphasize the clinical, it might be wise as one or all or several are discussed, to reserve a few minutes in that

discussion, to ask ourselves: how does this translate to community? Because it's the discussion over time that will help us take the kinds of approaches that are being suggested here.

We won't -- we're not going to, for the ease of the chairs and the staff, we don't have to reach consensus on what the community measure would look like. But it will begin to give us a peek into what does it mean to think about something in a clinical way -- in a community way?

If we were looking at obesity or heart disease or some other, what in essence is a clinical outcome, we could ask ourselves what do we think from a community perspective are really causing those outcomes, and it isn't the clinical intervention measure that we're looking for.

It's the measure on the community side. So it's a suggestion of how to begin to weave into the discussions here what will be

useful for the staff, because you're so clinically oriented.

That's not a criticism. It's just, you know, the nature of the work that you've been doing. It gets to your point, Paul, which is this is -- it could potentially be a conflict of cultures, and if we're successful, it would be a blending of the cultures, and what we accomplish is the push from NQF, which is seen as a reputable entity on the clinical side, becoming a reputable entity pushing on the community side, which is what those of us on the community side, I think, would like to have happen.

DR. JARRIS: So Bobby, it's a great suggestion, as always, and one thing I'd like to suggest is we also look at it from -- I mean, what's labeled behavioral in that NPP concept, and I don't like that term necessarily. But there are those questions about, you know, we could have clinical set, community set, but people don't take advantage

of it.

So we really want to look at, okay, what are the social norms, the drivers, the other things that will enable people to make the healthy choice once available. So I think looking at all three levels could be important. I had Ron, then Larry, then Matt.

DR. STANGE: And just a process thing. After we do these questions, Helen, I wonder if some of these other ones, the comments that will come up are similar to the general points that we've had, except for 2C on disparities. I wonder, since we have ten minutes left, I think we should end this at quarter of, if we want to make sure after we do these comments, if we jump to that and save a little time, so that we at least get a group discussion of that.

If there are important things people have to say on some of the other ones that didn't come up, you'll tell us how to get those to you.

DR. BURSTIN: I'd like to quickly do evidence as well, because I think it's an important one that's already been raised.

MR. BIALEK: I'd like to build on Bobby's comment for a moment, and I'm wondering if under the population health measure evaluation, the additional guidance and context, if we could benefit from there being two columns, one column being the clinical preventive services, and the other being the community preventive services and interventions.

Because when I think about changing all of this language and all the wordsmithing, it may become incredibly confusing and provide less guidance, because the way we think about the clinical preventive services may be different than the way we think about the community preventive services.

It's just a thought to throw out there, rather than trying to fit everything into the same set of criteria, same set of

guidance for us.

DR. JARRIS: Larry? Okay, Matt.

MR. STIEFEL: It's probably gotten a little out of phase, but Helen asked about a suggestion for accountable entity. I actually think there's nothing wrong with being specific and clear about accountability. The idea is just to make sure that it's broad enough.

So maybe just a parenthetical statement, specific accountability, including multi-stakeholder groups. It's not sufficient just to have the stakeholders at the table. There still needs to be clear accountability.

DR. BURSTIN: Okay, moving right along. So let's quickly, page three there. Let's just quickly keep going through importance, and again, this is not your last look at it. Disparities is specifically listed under performance gap as well. So I just want to mention that there.

There is a requirement, as part of

our evaluation, that there's a demonstration this a problem. There's a performance gap in this area, and it does include specifically quality. Again, this is quality of care. We'll need to potentially round that out. But quality of care across providers and/or population groups.

So I think that's something we wanted to specifically understand, this issue of variation. How would you look at variation across communities, for example? How is that a different framing of whether there's a performance gap in a given measure?

DR. JARRIS: It's also within communities. So we could have two communities.

DR. BURSTIN: Yes, yes. That's why it specifically says included, but not limited, to disparities, of trying to look within communities at populations as well.

MS. SAMPSEL: And I think my comment is probably more global about this

section specifically, but probably goes all the way through, and that's the use of the word "patient." It doesn't communicate well in communities, as well as I don't think that's what we're getting at with a full population.

So that would be the one thing and, you know, especially in disparities, you don't always consider someone a patient, and there's a lot of nomenclature issues in those populations in talking about patient.

MR. STIEFEL: Yes, and along the same lines, maybe a global search and replace for things like "care" and "patient." So disparities in care is too narrow. It's also disparities in the determinants and outcomes of health that we care about.

DR. JARRIS: Michael, then Larry.

DR. STOTO: My point was actually going to be similar to that, that this idea about performance works well in the world when you think about process measurement primarily.

But I think that outcomes is more important to bring in here, and maybe even --

MR. COHEN: The reason I brought this up earlier, in our organization, we do a lot of work on health equity, as kind of a fundamental element of our work, and always with the community as the level of analysis. One of the things we found commonly is that the indicators that are available are the indicators that are not measuring the things that our thinking indicates are most important.

That troubles me, and that's why I brought this up actually at the beginning, in terms of the overarching, rather than as a subset of this. I don't know what the purview of this group is in terms of one of the criteria being kind of available measures.

But I think somewhere in some way, as part of the credibility of this, it's important to indicate that there are some very important measures that are lacking, or at

minimum, that are inconsistent between different communities.

For example, some of the work that was done recently by Robert Wood Johnson called MATCH, which is looking at counties that I'm sure Bobby's probably one of the most familiar with. Because it's looking at a county-wide level, Oakland/Alameda County, where I came from, come from rated very, very high.

When I look at what's going on in Oakland, there are horrible inequities that are not showing up, because of the measure of the data that's used. I think it's a really good example of unintended consequences. So I just want to note this. I don't know, Helen, exactly where it fits here. But I think it's an issue of critical importance, or otherwise we'll continue to drive things in the wrong direction, and say see, we're making progress.

DR. JARRIS: You know, Larry, we

really tried to address this issue with the NPP process, in which we introduced the World Health Organization concept from 2002, which is that you need to have a measure of goodness and a measure of fairness. The measure of goodness is the average performance; the measure of fairness is the difference between the healthiest and least healthy, or the most and least disparate group.

We could not get that through the NPP. They couldn't, it was considered a quote, "new concept," and they didn't want to introduce a new concept. But I would want to bring that back here to say, you know, a perfect measure would not only tell you the average infant mortality, but it would also at the same time tell you the difference between let's say the Caucasian and African American, Caucasian and Native American, whatever the appropriate population is.

Without that, you know, like you said, how could Oakland possibly be considered

a healthy place if you walk through much of it, or at least --

MS. MERRILL: So it's the equivalent of the confidence interval.

DR. BURSTIN: Some of that will come up as we talk about the signs of acceptability in the measurement of properties. We talk a lot about the precision of the specifications to get at a level of analysis most appropriate, to be able to see what's, where you want to be, and that might be an interesting issue, is it to the most granular level to be able to see the differences.

DR. JARRIS: Well, but even forcing the -- because again this is -- we all awfulize about health equity. But until we actually force the system to look at it, and you can force the system by saying your measure has got to have an average goodness and a disparity component at the same time. Now there's going to be a gap, because we

don't have it. But if we don't require it or push it, it's just never going to happen.

DR. BURSTIN: Yes.

MR. COHEN: And I think also, on that point, that there are some, when we looked and we did research on this, on what the underlying community health factors are that relate to the key behaviors and most important, to the leading causes of death, and we looked at the ten leading causes of death, most of which are also the ten leading places of inequity and cost and disability and hospitalization, and we came up with 13 community factors that we've laid out and have identified, we had a very, very hard time and we're working on it again.

But identifying indicators. It's not even a question -- it's a different set of indicators that we need, if we're going to talk, for example, about quality of social interaction. You know, you can guess things. You can say, well maybe it's percentage of

people voting. But it takes us very, very far afield when we talk about harmonization, from patient-oriented.

It's not just replacing the word "patient," but it's a very, very different way of thinking. I really think it's important, and it's one of the main reasons I'm here, to emphasize this very important paradigm shift, even if we can't get there right away, but to be very clear that at least from my perspective, that's the goal that has to be reached.

Not only in population, but as someone said before, in starting to shift the clinical measures as well, so that clinical thinking starts to think more about the community factors that make people sick or injured in the first place.

DR. JARRIS: Reva, and then Mike.

DR. WINKLER: Just to respond to Larry's comments about available measures, in the last decade that NQF has been doing this,

this has been a common theme, of whenever we do these projects, the measures we have available are usually, almost invariably, less than what people want. There is this general shared sense of yeah, okay, but they're not what we're looking for, and that has just been a common theme. So there is nothing new happening here.

We have seen evolution over time. It is slow. But ten years ago, the idea of an outcome measure just was not even considered, and now they are pretty much what we do. So things do change, but availability of measures is one of our serious issues for everybody, and it really would depend on the measure development world, you know, who is creating those measures, and what are the incentives for them to develop those measures, so that you have them.

It's going to be the same issue for you all that we've certainly seen in pretty much everything else in the measurement world.

So the one avenue you have is certainly to identify what those measures are. Be specific about what you're looking for and what we need.

DR. JARRIS: Matt, you've put yours down, so maybe Sue and then Bobby, and we have like two minutes left. So let's be --

DR. PICKENS: So I'm going to be quick, and I hope what I have to say is relevant. I think what Larry said is extremely important, because when we do these broad-based measures of what the community looks like, how many people have heart disease, what is the asthma rate, and we take it to the community, they raise their hand and say yes, we know that, but that's not what's important to us.

What's important to us is livable wage jobs, our kids graduate from high school and nobody gets shot on the way. So those are kind of the measures that we, in order to make this even acceptable, I guess, to the

communities we're writing it for.

DR. JARRIS: And we're moving more towards that concept of well-being and less clinical illness.

MR. PESTRONK: Helen, what you were doing was walking us through Attachment 4 and pointing out to us how the typical NQF evaluation criteria have been modified or could be modified to better address the population health measure context.

This conversation has been about that it needs further revision in order to be useful. Yet later on today, we're going to be looking at what are ostensibly population or -- so my assumption was, let me start there, that we're going to be looking at what some people might think are population health measures, and that's the reason why that's what this group is.

So if in fact the guidance and context need to change further, how are we accomplishing the work we're supposed to be

accomplishing here, if in fact, we don't have the criteria and guidance correctly specified before we go about doing our work?

DR. BURSTIN: I think the measures that are before you today are clinical, and I think they fit our usual paradigm, which is why we actually held off on giving you any of the ones that were submitted, that look more population-health-oriented, until you have an evaluation criteria that will effectively allow you to look at those measures.

MR. PESTRONK: So what we shouldn't be thinking we're doing today, or over the course of these meetings, is actually the real work of this group, or --

DR. JARRIS: I think we could look at ourselves as grounding ourselves in the NQF methodology, so we have that foundation as we try to go forth. You know, and frankly, if we all sat down in the room and tried to take population health on now -- what an immensely complex task. So let's, I'm glad we're

starting somewhere, that some of this has been worked out.

So I've been negotiating with Kurt on your behalf, Matt. You may get the last comment here.

MR. STIEFEL: 1(c), I'm not sure which page that is. I think that framework is not sufficient for the work of this group, in that evidence, sort of causal pathway of outcomes, intermediate clinical outcomes, patient experience and efficiency is not broad enough for the work of this group. That's a very clinical focus.

It, for example, doesn't include behaviors, and also it doesn't include the social and environmental determinants. So in the causal pathway for this work, it, I think, needs to explicitly include and articulate that we're talking about -- I mean, behaviors is one of the stated purposes, and the community or social and environmental determinants are critical in the causal

pathway that we're talking about but aren't listed here.

DR. JARRIS: It might be a critical and a clinical pathway. I mean, if you look at a patient with chronic illness that sees their doctor every quarter and pretend it's half an hour, that's .02 percent of their life. 99.98 percent of life, they're determining the care and their health. So it really ought to be part of the clinical measures also.

DR. BURSTIN: Just to tee up for our last second, if we could, just if you could look at 2(c), and we can return to it this afternoon as we have our discussions, but 2(c) on page six is what we currently have for disparities, and since it's been so prominent, I want to at least put it on the table here.

We have traditionally been trying, and again this has been a bit of a forcing function on our part, to ask that measures be stratified, Nicole and Robyn have been leading

our efforts here, by race, ethnicity, SES, whatever the case may be. What we're often finding is it's more dependent on the data platform than it is the measure itself.

I think it would just be helpful for us to have a discussion, maybe not right now, but maybe in the afternoon discussion, after we figure out what population and community are, and how disparities fits into that. Perhaps we could just talk about: is there ever a justification, for example, for not including stratified data?

DR. JARRIS: There are two sides to that, so we should talk about it. Because let's take the Alabama Health Department that doesn't have two nickels to rub together and a really sick population, and then compare it to LA, where everyone's too skinny and goes to health clubs. Who's doing a better job? Which community is doing a better job? So there may be a place to look at, you know, risk adjustment.

DR. STANGE: So let me make a couple of summarizing comments and suggest we actually do take the break, because we need to clear our heads, and the next part is really another high impact thing that we're doing, that's about the stuff we all care about. So what I heard is some of the charges that we've received, is to just, there's kind of a searching function, looking for key words like patient care, health care, and just thinking about people and health and well-being, for some of those things about disease and patients.

Another is actually to start with the right column and think about that, about the similarities, rather than transferring over from the left column. So starting with populations and think about how you want to measure that, what level you measure that. Think about community as a participation community. Starting in that right column, what would that look like?

The really important points that we actually heard from Andy, Robert and Matt about who's the responsible entity. So they talked about shared responsibility, partnership, accountability that includes a multi-stakeholder group. That's a huge reframe from one organization that you can hold their toes to the fire.

But if you look at how to make things useful and feasible, that's going to be the transformative stuff. So that's a huge reframe. So think about what that means for the right column. Thinking about some of these, what's there, this little word of disparity, what that means for equity and how you think about that for the different populations.

So that's a ton of work to do for a next draft, and then I assume if we have other comments, we should email those to Elisa or -- and then you will give this back to us sometime, and we'll have a chance to revisit

this and read this? Okay.

DR. JARRIS: Okay. So eleven o'clock, the LA folks are calling in. So let's take a five minute break and be back at 11:00.

(Whereupon, the above-entitled matter went off the record at 10:51 a.m. and resumed at 11:12 a.m.)

DR. JARRIS: Okay. Well, thank you very much for joining us. In the room, I'd say there's about 25 different folks from both public health, clinical, insurance, as well as business groups and others, governmental positions, HHS.

We're very interested in hearing about the paper you've begun to work, and I think very interested in providing feedback, as we all stretch to really define better some of these terms and some of the concepts here.

I want to thank you, Steve and Dawn, for taking this first stab at it in what is a very complex area, to actually try to nail

down these definitions.

We were actually thinking this morning that the work you're doing here is a good start forward, because many groups have these discussions without even attempting to define what they're talking about. So I want to thank you for taking a stab at this, and please lead off.

MR. TEUTSCH: Great. Thank you so much, Kurt, and thanks to all of you for allowing us to work with you on this project. Dawn and I have been now involved with performance measures for a long time, but we were first asked by NQF to consider working on this paper just about three weeks ago, two-three weeks ago, and it wasn't till last week that we actually were told to go ahead.

So what you are having from us is some of our initial thoughts about this work, and it's an area that we're excited to work on and we're excited to work with all of you. I do know many of you, and sorry that we cannot

be there with you. So thanks for allowing us to do it by phone.

The person who is going to be doing the lion's share of the work at our end and drafted most of the outline that you saw is Dawn Jacobson. So she'll be doing the presentation this morning, and I hope most of you have had the chance to review that, because the slides obviously are only going to be able to do a synopsis, have a brief synopsis of some of the ideas.

Then we're looking forward to hearing from you what you're going to need, so that we can flesh this out and modify it to meet your needs. So with that, I'm going to turn it over to Dawn, and hopefully you all can see her slides. Do you have her slides up, Kurt?

DR. STANGE: Yes.

MR. TEUTSCH: Great. So Dawn, why don't you go ahead?

MS. JACOBSON: Okay. Good morning, everyone. It's very good to be part of this

project. Just so you know, I cannot see the slides on the webinar, so I'm just using my own slide sets, and I will be try to sure to say advance slide. Elisa, if you can just let me know periodically if we're in sync, that would be great.

So before I even begin, we definitely acknowledge there's a lot of different terminologies, and a lot of different ways that the concept can be defined. So we definitely look forward to hearing how you choose to define them. Next slide, please.

The proposed analytic framework is really based on a gentleman who created an approach to measurement maybe in the late 90's, by the name of Mark Friedman. Some of you may have heard of him.

DR. STANGE: Yes.

MS. JACOBSON: He worked at the State of Maryland Department of Finance. He had a long career in the public sector, and created an approach that we think is very helpful, in

that it clearly distinguishes sort of what these population health big picture goals for various levels of community are, from these sort of organization-specific, provider-specific, program-specific goals, but links them very nicely. Again, the concept that Friedman has proposed is that any public agency and really any system that would consider improving population health as a primary objective, could then apply this sort of framework.

Next slide, please. So then it sort of begs the question then of what system, how do we define system, what types of providers work in these systems, and, again, we all know this is very complex. We all work in different aspects of these different systems.

What this slide shows, and what the proposed framework would be, is really taking the Institute of Medicine definition of the public health system being this network of partners, and you'll see on sort of the left

the third bullet. "The public health system is very large, could be work site, schools, other sort of public agency systems that might have health as an objective, especially in social determinants related to health."

So loosely connected non-profit systems, and there's others, you know, we could list there, and I'm sure everybody will have something else they want to put in that sort of catch-all category.

But what we thought would be helpful for framing is that we would focus on then the two systems, the clinical care system, health care system, medical care system, whichever term we choose to use, and sort of this network of units that deliver governmental public health activities, because those are really the two systems that clearly have health and wellness as a part of their vision and mission.

Then by keeping those three categories very distinct where possible, then

there would be providers or practitioners, and again choose your term, that would then reflect delivery of services within those system, so we propose sort of three systems and three types of providers.

Next slide, please. This is a way of very simply showing the connections that Mark Friedman really created. So what you'll see in the next few slides is that the sort of linkage for population health improvement and what an organization or system that we propose would do, the types of activities that would lead to planning, getting to agreement on what collectively we do to improve population health through shared accountability, shared work, who does the types of planning, who does the types of measuring.

We didn't quite get into quality improvement with our examples, but really again, the clinical care system, the public health system has been doing these things, sort of separate but in parallel, and I like

the comment earlier this morning about complementary activities and metrics that might not be identical.

So if you focus on the blue box for a moment, we can -- population health means. But if we think about sort of even the U.S. Constitution and the delegation of who does the health and welfare of the country, we consider this sort of the public good, the common good of population health, that different systems would then work together to ensure and move forward.

You'll see inside the blue box we put health outcomes, which we'll talk about in a minute; behaviors; and then social determinants. So the more upstream determinants that would then influence the health and welfare of populations.

Who directs that planning? I heard comments about who the owners of these types of activities? A lot of these sort of common good, public health planning activities have

really been done by the governmental public health system, in some areas of the country in partnership with the clinical care system or the non-profit system, as part of this, you know, state community health assessments or improvement plans.

Part of the framework we'll be getting a handle on, sort of what different areas and levels of community have really prioritized over time, and kind of do a scan and better understand that.

But then you have this green box, of which whatever system you choose to focus on, which we'd like to focus on the two primarily, you have organizational sort of performance and things you want to do well, and then really provider level.

These are oftentimes reflected in an organization's strategic plans, the vision operational plans, and even very specific work plans or quality improvement efforts that would happen in a clinic or a public health

program, and these activities are occurring, measurement improvement really in both of those systems.

But it's at the planning, of course, and sort of understanding who might have ownership, and how we would integrate those over time. Next slide, please.

This is just a quick reminder that when you think about population health improvement, there's a lot of competing, if competing's the right word, indicator sets. You have at the national level things like, you know, the new strategic priorities coming out of health reform. You have Healthy People, which has been around for four decades.

You have Trust for America's Health. You have sort of national level priorities for population health improvement, and then they report and measure things in certain ways. But that cascades down to maybe a state plan, and then if you go to the very top of the

pyramid, I put county or community-based organization.

But you could put accountable care organization plans. Kaiser, you know, has a lot of sort of population health improvement activities they do for their immediate population and sometimes the broader population of a county or state.

But there's this complex cascading that I know you're well aware of, that really starts with planning. Part of this would be understanding sort of who was prioritizing what at different levels. Next slide, please.

Then you get to then really the organization level planning. I don't want to worry about this box so much. That's Mark Friedman's box of how you would sort of write structure, process, and output measures for an organization that's targeting, we use the word "client," that's -- in public health sometimes you don't use the word "patient." Sometimes, you know, organizations have very specific,

you know, ways that they discuss the people they serve.

But on the left, then, is just sort of, you know, what Mark Friedman puts out, is how you would target then provider-level metrics, and really assess how well the organization is performing. That planning often is very internal to an organization. Next slide, please.

So then it gets to well, how are you going to select then ways to measure performance at these two levels. Reports come to some agreement on what types of things you'd be measuring, and so I put some examples of categories of things you could decide to measure.

So on the left again, we have this population health level, and this is a reminder, it's health outcomes, behaviors and social determinants. Then the types of things that are traditionally measured in the public health community.

Life expectancy, quality of life. We talked about disparities in equity, which you can really take any health outcome or behavior and sort of break it down by race, ethnicity or income, and get an idea of equity.

Disease, morbidity measures, of course mortality metrics, early mortality metrics, and then you get to, you know, the bottom of the list there, which really gets into more upstream things. You get into behaviors, environments, homes, social environment, built environment, that can sometimes plan at the population level, depending on your data set.

Since for every sort of thing you would prioritize at that population level, you could sort of decide which category is the most relevant to your work. Then you would move over to the green side, and really decide then what priority, high value clinical and community intervention that would then deliver and measure, really within or maybe across the

systems, if there is some commonality.

So of course what the public health departments measure, you know, we look at policies that are created and cover a percentage of the population. People informed coalitions, stakeholders that are engaged, timeliness and completeness of surveillance, you know, outbreak investigations, and we're moving into social and built environment metrics.

Then what we added to the bottom is really, then, what I currently see as sort of the provider community. Access might have some overlap, screening, treatment received, patient safety. It would be a way of sort of again having these complementary measures across the systems that would then collectively improve population health.

Next slide, please. So how do we help you do some of this? We'd like to look at the current health assessments and improvement plans, and see if there are

certain party topics that we could advise you sort of rise to the top. Examples of that would be like the ten leading health indicators in Healthy People, which have been put forth in the past. There's the State of the USA indicators.

But again, there's competing sort of groups that want to put forth the top ten things, and I want to put a little bit of a joke in here. All you have to do is sort of do what Friedman did with CDC, and pick six winnable battles, and the advocates are lining up to create numbers seven, eight, nine, ten. So prioritization is hard, but if we could work with you to get to sort of a priority set of again, these population of impact topic areas, I think would really move understanding of population health forward and what we do to change it.

Then we obviously have certain systematic reviews, clinical guides, community guides which should help inform how we

prioritize our interventions then to improve health. Then we move into measurement of what we prioritize, and again if we can sort of work with you to decide if these two levels work, to keep them sort of in their separate box and if these sort of proposed three systems, with focusing on two of those, is something that would be the way to move forward.

Next slide, please. I'm moving into a few examples now of how, you know, working at the local level, how we would sort of, I'm not even getting to define community. But once we define community and who would be working towards those, which will vary, of course, all across the country, how to identify common data sources.

What I wanted to introduce to some of you who have not worked in the public health arena, is that similar to the clinical care system, we have performance databases. Some of them are getting integrated with meaningful

use, you know, requirements. But some of them are just simply if you go to the right column for a second, some of it is less surveillance, and we have a stand-alone database in LA that really lets us understand our activities and performance in that area.

It's not simply measuring percent of children who have an elevated blood lead level. It's actually our case management measures, what we would consider our public health intervention and how we measure performance of our staff that go out and do those types of case management activities.

Of course it leads into, you know, home investigation, mitigation of lead and lead abatement. But we do have these data sets, in other words. So we have to do some sort of scan to really at least put forth what we think large urban health centers, or I'm sorry, health departments, would have available to provide measurement of their systems.

The health care system has had about 30 years' lead time on this. They've had of course more money in some way that's been more high profile. But we really have to start looking at then how we measure with the new systems, and link it back to these population data sets. The example that I put there is just to really show you how in certain communities, like LA County, we have robust data sets, and we have to choose if we're going to use the National BRFSS data, if we're going to use our California Health Interview Survey, or own LA County health survey. New York City is similar to this.

So vital records, you know, is obviously available at different levels. But we have competing data sets sometimes. Now those of you that have worked in the county health rankings know that a lot of small counties don't have that. They're lucky to get a data point out of BRFSS, you know, period.

But we really want to do a scan and understand where in the country we could start moving towards this real integrated shared accountability approach with data. Next slide, please.

Then for moving towards improvement, again we have sort of competing benchmarking sources. In public health, we often look to Healthy People to see what the national target is. But there is again, state, county. There's professional association, benchmarking, and again you can divide these into these two levels, sort of a population level benchmark and then, you know, again a system provider level benchmark of performance, which could give a nice picture of how to improve over time within these systems and collectively across the system.

Next slide, please. So then how do we start thinking about these investments we're making in both of these systems, and this is very preliminary. This is something

I pulled together a couple of years ago. We can move into much more complex logic modeling and systems modeling.

But the idea is that if we can have ownership, some sort of ownership of who does what. It's not going to be easy to figure that out, but at times, they're going to very clear, clinical preventive services that really the clinical care system will do. That being said, of course, there's some health departments in this country that still do primary and specialty care services, and how do we acknowledge that? So there's going to be some overlap.

But certain metrics will fit nicely into one of the two systems. So in this schematic, obviously clinical criticism is on the left and more of the -- what the health department tends to have, they feel they have sort of ownership and direction over is on the right.

Then there's this idea of overlap

within the systems, and then delivery enhancements, which may or may not have overlap. So again, the schematic is not perfect. It's meant to stimulate discussion.

But then there's going to be system changes, whether it's meaningful use, IT integration, whether it's deciding collectively that a certain policy has to be implemented in concert with changes throughout the clinical care system to, you know, increase maximum impact. It's those types of things that we want to try to capture in a logic model.

So next slide, please. So how does that, might that play out? Now granted these aren't measures yet. We can start writing measures for these things as well, but we'd like to hinge this on evidence, just like we all do, and again, this A and B recommendation from the clinical guide, if there's recommended interventions in the community guide.

I just took tobacco and put them in the Venn diagram. We can start assigning ownership and then who would measure them and the data sources that would measure that, if possible. We probably can't measure everything, but we can, you know, address that as the issue comes up.

But then look at system changes, that you know, who really is responsible for reducing client out of pocket costs? Is that health plans? Is that a policy that the health department -- you know, it could be a series of interventions. But it ends up being sort of big paradigm shifts or system changes that would go in those yellow boxes, and you know, I kind of put sort of the types of system changes below. I know they're obviously recommended in the treatment guide.

That's tobacco. Then if you go to obesity on the next slide, it's a bit more difficult. There's a lot more, and you'll see then, if you go to the community side for a

moment, that could be the governmental public health system or other system partners. It starts feeding into work sites, school days, urban design, which, you know, who owns that.

But if we can move toward again putting it in those three systems, both the evidence-recommended interventions, and then move towards understanding how we measure that complementary together, I think we can really move measurement and performance and impact to the population health level forward.

DR. JARRIS: Dawn, I'm sorry to interrupt, but your voice is falling a little bit. It's probably fatiguing from speaking so loud.

MS. JACOBSON: Yes, and we're almost done. So we're just on the last couple of slides. So I'll hang in there. Next slide, please.

So then this is, you know, Steve can definitely. He's worked in this area for quite a while. We can take this sort of

clinical guide and community guide to to the next level, and I think the work of the Steering Committee can then get into other facts, you know, contextual factors that have been brought up.

I mean is this of value to the community? Is it feasible? Is it measurable? You know, there's all sorts of things that can play into how this Committee would then prioritize a set of interventions that's doable. There's one word of caution that from working in measurement and quality improvement in a public health department, measures can get out of control quickly because everybody has their favorite metric.

Part of what we'd like to do for you is sort of provide some guidance on that. However, if you pick ten population indicators, for example, population health outcomes, just ten, and we recommend that at least there's one then performance measure that would be seen as influencing that

outcome.

Then if you have the clinical care system and the public health system and the other system measures, you'd have, you know, quickly get to hundreds of measures very quickly. So as you work through those issues, I'd be glad to talk through, you know, how we've tried to limit measures, you know, but keep them essential over time in LA County.

But there's different ways that you can then prioritize these things. And the final slide, please. How would we like to help you with some deliverables? That you'd create a matrix, you know, that would really show the synergy for how to prioritize, implement and measure prevention activities across the two systems.

We could recommend three or four priority areas. You could recommend them to us, you know, but the idea is that we'd start making, you know, a more complex logic model of how this cascades, and yet is complementary

across the system.

I say two here. You may decide that you want us to do all three and bring in some of these other public health system partners, and we're open to that. It makes the scope of it bigger, however.

And then really then strategies for how you would collect data and report them, and maybe even do quality improvement projects, complementary ones across the two systems. We very much look forward to a robust discussion. Thank you.

DR. JARRIS: Thank you, Dawn. This is Paul Jarris. So while we were here, Kurt and I and Helen just had a brief interchange, to discuss really the purpose of the paper and the purpose of the work.

As I understand it, the work by Steve and Dawn is really done to inform us, the Committee, and be a group that can research things or look for things that we need research between meetings and to inform us.

So it's not really for an external audience. It is for us, so hopefully that can frame part of our conversation. I did have, if -- I have a comment, and not specifically regarding the presentation, thank you for that, Dawn, but more about the paper.

We appreciate the first stab at definitions because that came up again this morning and hopefully you were able to listen to part of that. But mine in particular is about the definition of population health from Turnock because I think that although that's a simple, concise definition. I think it loses some of the other definitions out there, and in particular, it loses the whole aspect of health equity, in that this is again talking about overall goodness. It's not talking about goodness and fairness.

I think the three other measure definitions which I have been aware of, whether it's Kindig or Young or Dunn and Hayes, each hit that. The Dunn and Hayes

definition of '99, the Canadians, actually gets much more into the areas of social determinants and environmental, as well as does include clinical.

So I'd ask you to take a look at those definitions again because this one, although it's simple and concise, doesn't really capture all the depth of population health. I'm happy to read -- why don't I do that for you?

So this Dunn and Hayes in '99, I believe they were two Canadians, as the Canadians were trying to figure out how do you define population. It's a little bit long. It says "The health of a population, as measured by health status indicators, and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development and health services.

"As an approach, population health focuses on the interrelated conditions and

factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations."

So it's pretty broad, it's pretty long, but I think it actually is a great conceptual definition.

MS. JACOBSON: We're open to other definitions. I think that one thing I've learned in public health practice is keep it short and sweet. But I would say that, you know, to sort of take that definition, I think that very nicely, within the Turnock definition, puts more specifics on extend beyond medical treatment, and it really then puts socio-environmental factors and it lists them. Yes, we can look at finding a way to do that, yes.

But also, I mean I guess one thing

I'd like to ask the group is, and I know this from experience. We could start putting definitions out there, and we can advise. But even early in this discussion, I think this group needs to figure that out. You know, we can find a list of like ten different definitions and have you talk through that.

Is that something that you would find helpful, just to give you, like every sort of the, you know, the major definitions so you can work through them?

DR. JARRIS: Larry.

MR. COHEN: Hi, Dawn. This is Larry Cohen from Prevention Institute, and I'd like to just make general comments, as well as responding to that. The general comments are I just found your presentation really, really helpful, and also I'm a very big admirer of Mark Friedman's work, and I'm really glad you based it on that.

I mean I do think we have, I don't know if the right word is consensus, but we

have a general perspective about the kind of definition we're looking for, and I think it's a definition that's a bit broader. I really like your notion of short and sweet and concise.

But at least I'm not -- well, I hope I'm speaking for a lot of people when I say that we need a definition which includes a sense of equity, and also a definition that includes a broader sense of social determinants. I was struck, when you were using Mark's work, Mark Friedman's work, you know, I don't know whether he's been doing more recent thinking on these kinds of efforts.

But the public health field has evolved a lot, and in particular has evolved in its emphasis on health and well policies and multi-sectoral work, which goes beyond medical care and public health as the two main players.

I think a lot of the analyses need to

go beyond that. So I would go beyond, for example, community service guide, you know, the things like that that are very helpful, and I would look particularly at the National Prevention Strategy and the National Equity Strategy as places where we really need to bring in content.

You know, I thought that the, you know, the Venn diagrams, at least the way they were pictured, there was very, very little overlap between health care and public health. It was kind of two almost -- well, I wouldn't say competing, but separate and parallel measures, sets of measures.

The thinking I've been doing and related to the Center for Medicaid and Medicare Innovation, and how public health and medical services linked, is the health care playing a much stronger role in identifying, advocating and intervening in community health. You know, I see that as a shift, and I would hope the indicators would be

indicative of that kind of shift.

I'm realizing it's a paper we wrote called "Community-Centered Health Homes" is something I want to share with the whole group, as well as you, Dawn and Steve. But that I think that the, at least from my perspective as one Committee member, that a movement to a certain extent, from the paradigm of the public health system and the medical system as the two systems, and from kind of what they traditionally do, is absolutely required if we're going to be defining quality and best practices in community health.

So I would hope for that kind of reconfiguration, and I think there are a number of people here, and that it could be very, very worthwhile to have some of the discussions about what that looks like, because I'd hate to just kind of toss that back into your lap and say it's your problem to figure out what I'm talking about.

I actually, you know, my tendency would be to revise the agenda in some way so we could have some of that kind of conversation here in depth, at least as a subcommittee, and really start to define that kind of way of thinking much more effectively.

MR. TEUTSCH: This is Steve again. Thank you for those comments. The recent IOM report that was released on measurement really looked at two different levels of population health developed, you know, in fairly narrow terms, one was sort of the sum of individual health, which is traditionally how we've done it in public health, and the other was really looking at the overall health of the communities, which really were not those individual level indicators summed, but really looking at community well-being.

I think one of the questions I would have for you, and it sort of relates to what you were saying, Larry, is how broadly do you want to get into the measures of community

health broadly written, that is the health of the community, as opposed to simply the sum of the health of the people in those communities.

DR. JARRIS: I think, and I'll watch the Committee's reaction, the sense this morning is we very definitely want to get into the health of the community, and that one of the things to consider are the three tiers of community preventative services measured at the community level, patient behavior and behavioral choices, and then third, the community, and I shouldn't say patient, excuse me, individual people's choices, and at the third level, the community factors which will address both self-determinants of health and the environment which will provide people the opportunity to make healthy choices. So I think we want to hit all three levels of those.

DR. STANGE: Dawn, excuse me. This is Kurt Stange. If I can intuit your approach using Friedman's results accountability

paradigm, that made you focus on the clinical system and the government public health system, and it made some sense. Those are both systems. They both collect data and they both have resources to then do something with that data toward their somewhat overlapping goals.

So I noticed in your Venn diagram not terribly overlapping, which probably reflects the reality of the current system, but not where we need to be. There was a really helpful idea in the morning discussion that I think could help you think of a third system that doesn't have that kind of rigid accountability, but the idea of shared responsibility, accountability or partnership among multi-stakeholder groups.

For the types of problems we're trying to solve here, if we just stick with classic clinical systems, public health systems, and just try to work at the interface between those two, we're not going to get at

the social determinants of health very well. We're not going to engage the power and potential of participatory community groups, of the business community.

Multi-stakeholder groups have the potential to do that and start to address that. So if you're looking to engaging the business community, they want some shocking things. They are surprising to some people, advocates for the social determinants of health, and for controlling the big sucking sound of the health care system.

So the business community wants us to spend less for health care. If you look at the decisions that state governors and county executives and so on are having to make, they're really spending so much for health care that they are not able to do anything to help businesses provide jobs, they're not able to do anything for education and other social and environmental, and other social determinants of health.

If we just stick with the clinical and public health and try to inch forward from those platforms, which we need to do, we're not going to engage the really transformatory partnerships. So if you just take that results accountability platform, and think about multi-stakeholder groups, that might unleash a lot of really creative stuff.

MS. JACOBSON: Let me just clarify here. I don't know if you can go back to Slide 8, but that is sort of where these other public health system partners land. Obviously, there's coalitions or collaborations that would crack, you know, and it's going to be highly variable, depending on your community and who has championed this much funding and who has grants to do what as we all know.

It sounds like this is a vote in favor of including sort of this group of other partners, and potentially seeking that down, what the work site business committee would do

with the education system. It makes the scope of this project much bigger, to figure out what the education system's doing at the state and local level. I don't know if we can even get that information to you.

DR. STANGE: So the thing that I wrote down, Andy and Robert and Matt this morning told us, though, is to think about not just as an "other" category, not about them as individuals, but what happens when they start working together. What that lets you do, and there are good examples of this, is it lets you take a whole systems approach.

Otherwise, you end up just looking under the light post, rather than looking over in the darkness, where the real problems and the real transformative solutions are. So if you just add that as a third bullet, you've got public health, you've got clinical health care, don't make it an other. When you're thinking about accountability and actionability, thinking about the multi-

stakeholder groups. I think that really changes a lot of -- changes a lot.

MS. JACOBSON: I think that we'll get into the strategies for then working across systems. Does that make sense? I mean there's a way that -- and the reason I say that is these systems, as we all know, have designed these stand-alone sort of performance assessment systems that don't talk to each other.

So there's stakeholder groups that get together. They don't even talk about measurement. They just talk about the ten things they want to do together, and they don't measure anything, because it doesn't move in that direction.

I guess I'm trying to find a way that, you know, multi-stakeholder is sort of the strategy, then, to link the systems.

DR. JARRIS: Maybe it falls under this health and all policy concept, you know, in terms of -- because there's amazing work

being done in economic development, in transportation, in education and many other groups, that they would never consider themselves public health partners. They're doing this work independently.

You know, we need to get to the table with them, and I think some of these multi-stakeholder consortiums are an attempt to bring those parties together. But we have to go, I agree. More broadly beyond this clinical and public health, and start looking at this health and all policy.

MR. TEUTSCH: Right. I couldn't agree more. I think again, the measurement committee at the IOM really tried to talk about two different kinds of accountability here. One was the direct accountabilities, through contracts, through performance measures, payments, things like that. But the other was what they called a compact accountability, where you really looked at all the stakeholders, their roles, their

commitments that they make to achieving some -- to contribute to a common end, and then how do you actually measure that.

The devil was in the details, because you can find some of these groups, and there are several, and I think you mentioned some. There's some sustainability activities that link transportation and housing and energy and the things of that nature that really deal with many of these issues, and then each of them make a commitment as to what they're actually going to do that you can actually measure, so that they hold themselves jointly accountable, rather than having kind of direct accountabilities.

I think that this is all fairly nascent stuff, but we can certainly lay out what some of those are, and the kind of measures that they actually try to use or have begun using.

DR. JARRIS: I had Ron, Matt and Michael, although Matt, you may have retired

your question.

MR. BIALEK: Hi Dawn and Steve. This is Ron Bialek. I very much appreciated your presentation, the good thinking and the approach that you're taking. A couple of quick thoughts. In the written document that we received prior to the meeting, you answered a lot of questions that I had in your slide presentation.

I just want to be sure that in your report to the committee, that you're as clear. For instance, it wasn't as clear to me your emphasis on policy, and it wasn't as clear to me your consideration of the community guide, etcetera.

So I think it's important just to be sure that we don't make assumptions, that all of us will take for granted that those are being considered. I thought it was great how you integrated that into your presentation.

Just some specifics. Something I didn't see mentioned at all was the National

Public Health Performance Standards Program, which really has established metrics, has been studied for reliability and validity, has been looked at in terms of impact on performance and outcomes at the public health system level. I'd just encourage you to look into that program a little bit, with regard to the paper.

Community assessment, as it is referenced, and you did talk about it. I just want to be sure that when we're talking about community health assessment, it's not only needs but also looks at community assets. In the recent definition or recent guidance from the Internal Revenue Service, it's more focused on needs.

So again, I just don't want us to assume that we're all having a similar understanding. Then lastly, on your last page of the written document, you spoke to the nine public health aims from a consensus statement. I was just wondering how, what your thinking

is to date on how you may integrate that into this work. I've been struggling a little bit with that, and just would love to hear your thoughts thus far on how you integrate those aims into this. Thank you.

MS. JACOBSON: Sure, and --

DR. JARRIS: Louder.

MS. JACOBSON: Obviously in this overview, we couldn't touch on every aspect we're going to do in the scan. But someone earlier this morning --

DR. JARRIS: Dawn, we can barely hear you.

MS. JACOBSON: Okay. Someone this morning mentioned that there are entities that are, you know, establishing sort of performance metrics and standards in the public health community, and I definitely want to include that as part of the scan. And of course then, you know, the various sort of again, organizations that are setting sort of measurement and performance centers for the

clinical care system as well.

So thanks, Ron, for the reminder. I mean we'd throw in the accreditation domains there as well. But going back to sort of these nine proposed quality categories that came out of HHS, I wouldn't say that I have a strategy in mind right now. I really put that in as, you know, work to be done and to be fleshed out, you know, in greater detail, as we work through the commissioned paper.

What I like about the nine characteristics is it brings it back again to this, you know, the concept of transparency and equity, and different types of things that we in the public health community sort of -- again, you think of the public good, the common good of health that we think about.

I think there is a way to integrate them. I have to cogitate on it a bit more.

DR. JARRIS: Thank you. Matt, are you passing over? Michael?

DR. STOTO: Thanks. Thanks, Dawn and

Steve. This is Mike Stoto, and I share Ron's comments about how valuable I think this paper's going to be and already is.

One of the things that we spoke about this morning, and Kurt mentioned, I think, is this idea about thinking through responsibility and accountability a little more carefully. We actually worked on the report, when I worked at the Institute of Medicine a long time ago, that fleshed that out.

I think you got the slides. I sent -- I emailed a couple slides to you just this morning. The idea there was that health outcomes were a shared responsibility of health care providers, health departments, lots of other organizations in the community, and we needed to sort of measure those, how well we're doing in terms of our shared responsibility.

But in addition to that, we need to measure the performance, the actions of a

variety of different players, and hold them accountable for that. So we're talking about measuring accountability of health care providers and measuring the accountability of health departments. But also of employers, schools and parks departments and all those.

This framework kind of lays out a way to sort of jointly measure shared responsibility for health outcomes, and the individual accountability for what these different entities do towards that goal.

MS. JACOBSON: Actually, could you go to Slide 7?

DR. JARRIS: Volume again.

MS. JACOBSON: Whoever's managing the slides.

DR. JARRIS: Dawn, please speak up.

MS. JACOBSON: The phone is right by my mouth. Can you hear me better? Can you hear me now?

DR. JARRIS: Yes, we can, much better.

MS. JACOBSON: I guess the microphone has to be right up close, I guess, in the phone today. If you go to Slide 7, if someone who's managing the slides can go to that slide.

DR. BURSTIN: It is.

MS. JACOBSON: That's really what we're getting at there, is that we would want to propose ownership of the types of activities on, you know, in the green box. If you give us leeway, you know Steve and I, and the folks we're working with, we will happily put forth who we think the owners are, and knowing it will stir a lot of controversial discussion.

But we can do that, and I think you could start writing measures, then. Of course, there's types of measures that a health department would feel they do that reflects their activities, and that the clinical person would do. I think you will find that it can be aligned quite nicely

within, for example, a disease outcome or a behavior outcome or a social determinant or built environment outcome, that's, you know, kind of listed over under the blue box.

DR. STOTO: So if I could just respond, I think that is the idea that we had in mind, and the question then becomes, you know, is it appropriate to assign specific responsibilities in a report that NQF might do, or is that something that needs to be done at the individual community level, because who's responsible for doing so and so may well be very different from one community to another.

So maybe there could be suggestions about potential accountable parties.

MS. JACOBSON: Right, and I think one thing that Steve and I will keep in mind is, you know, I've worked on healthy people, I've seen from the national perspective and I'm at a local health department.

Definitely, it varies and I love the

comment on a population case mix or risk adjustment. I think that, you know, I'm waiting for a major biostatisical breakthrough that some researcher does, that's going to start moving us in that direction. Because then sort of a percent contribution to a health outcome if we could move in that direction would be great.

But in the meantime, we sort of have, you know, at least at the local level, you know, local priorities will play out, and my concern is that Steve and I will default to the local perspective too much, and we would need to be reminded that there's a national sort of general relevance that has to be maintained.

But any guidance from the steering committee on how much, like across the levels of national and state and local, and even subcounty analysis sometimes. Any feedback you have on how you want us to break that down would be helpful, or what's important to you

would be helpful.

DR. JARRIS: Okay, and can you tell me, is Jacqueline or Jackie?

MS. MERRILL: Jackie. So this is Jackie Merrill. Hi Dawn. One of the things that I'm thinking about with this is the problem of non-linearity, and the idea of the logic model.

So I would encourage thinking that is not logic model-based, and that is, has a component of non-linearity. Because when you do that, and you start seeing the factors, the multiple factors that are influencing any single area of your diagram, that's where you can -- that will suggest the levers that may be appropriate.

So when you're thinking about-- what we're aiming for is we want to get some kind of indicators, and in our case, some of these indicators may come from unusual sources. So the stewards of the indicators may actually be groups that don't appear to be aligned

proximately in a logic model, but actually in a systems diagram would make sense. Do you understand what I'm saying, the idea that it's not a linear relationship?

MR. TEUTSCH: Jackie, are you suggesting just to show the complexity of the relationships and interactions, and the multiple influences, rather --

MS. MERRILL: I'm suggesting more than that. I'm suggesting that that actually can be a tool to help clarify some of the competing interests that you're talking about.

Now to actually diagram the complexity might be useful, because it's certainly something that I struggled with, and it's -- I mean it's not an easy approach, but I actually think it's the only approach that we need to use.

So that's just my suggestion, you know. I think I'm taking issue with the idea of the linear logic model versus the complex system dynamics approach.

MR. TEUTSCH: You know, I think you're right, because certainly if you look at the community guide, U.S. Preventive Service Task Force, they have a fairly linear model of how you get from some intervention to some outcome, as opposed to the more complex, as you said, systems dynamics models, which do understand not only the multiple factors, but the interaction of all of those that influence things.

So I think we can -- we obviously can't build those models, but those are the kind of things we can certainly comment on.

MS. MERRILL: Well, you might not be able to build a measurable model, but you could think about that when you're diagraming out your own work, because the point I'm making is that those kinds of models can suggest a lever. They can suggest the place where the intervention might, or some action or some suggestion might make a difference.

That might not be obvious when you're

doing it linearly. That's what I'm saying. It's sort of a tool to guide your thinking.

MS. JACOBSON: Jackie, let me ask you one question, that definitely we could, in our methods section, add that to our scan, and sort of basically say that types of system dynamic models exist, and sort of can help inform especially chronic disease management and synergistic population, you know, typical public health population-based interventions and then clinical care measures, and they're together in sort of this dynamic feedback group model.

We can add that to the scan as far as methods. But it also can be used very practically as a way to prioritize then interventions at various levels. What I found very exciting is in the putting communities, you know, to work.

In some of the systems models that Bobby Milstein and Jack Homer have designed through CDC, have actually been applied, and

a part of that grant process is to apply the local data in, to then help prioritize at the state level plausible futures.

So let me ask you this. I mean part of it could be scanned for methods that can help perform measure selection across the system. Then too it could be discussed as a prioritization tool as well. Is that what -- would you like to see it applied in that way as well?

MS. MERRILL: Yes, yes.

DR. STANGE: So at the beginning of this discussion, Helen and Paul suggested that one of the purposes here is for us to suggest to Dawn and Steve how they can do work that would help us in our work. What just they -- Dawn asked a minute ago, asked for our help in what levels would be helpful. It's worth thinking about what community means, what community interventions mean.

What levels are we thinking about that data would be helpful on is the question

they're asking us? How can they help us in that? But so let's get some back and forth. They're asking how they, you know, what input they can have from us that would help them frame it, and what other things could they be doing that would help as we're going and maybe expanding the charge a little bit here?

MR. COHEN: I actually want to lay out a question I have on this, what levels of data would be helpful, and a challenge to myself and to the group, as well as to those of you in LA.

Recently, I gave a large funder the advice that if anyone could take complete responsibility for an achievement, that they shouldn't be funded again, because my understanding of community-wide change is it must be contribution, not attribution.

I think that has a lot of implications for what we're talking about now in terms of accountability. For example, the health and all policies approach, Paul, that

we've been talking about, would say for example that transportation can have a fundamental impact on people's physical activity.

Earlier you used the word "exercise." But I would prefer to use the word "physical activity," because I think it involves a lot of things that don't traditionally get thought of when we think about exercise. I would like -- clearly, we could hold the transportation authority accountable for that, and that's already as you pointed out Dawn, a hard stretch and makes the paper more challenging.

But from my perspective, it's a clinical responsibility. I had an experience with a physician who I met, who was in tears when we had a conversation about prevention, because she talked about telling someone that day that he had pretty serious diabetes, and urging him, in addition to taking his medication, to be more physically active and eating better food.

Broke into tears when he left the room, because she knew that was a farce, because she knew the neighborhood he lived in. It just wasn't safe to be physically active, and he too, nodding his head and saying "yes," said he knew it was a farce. She felt she needs to speak up and do something about the physical activity in that neighborhood. That's part of what I would say is a community-centered health home.

The implication of that, I think, is that the data needs to be data when we talk about data being useful and contributing to quality. The data we ask for needs to be data that when we say something's not working well, we don't have the quality, that then moves the system to move in a way that's more effective.

I would say part of being more effective is physicians as advocate for walkable communities, for example, safe, walkable communities. I'm not sure exactly how to do that, which is why I'm describing it

as a challenge.

But I think it goes to the core of some of our thinking. How do we get the medical care system admittedly primarily doing patient care, but also taking some of the broader responsibility for people's health, because the medical care system has almost all of the credibility and has almost all of the money?

DR. JARRIS: Thank you. Matt. Matt has the answer, so that's why he's going next.

MR. STIEFEL: I think this follows Jackie's comments about systems dynamics, and looking at Slide 7. I have a little trouble sort of reconciling this framing of population indicators and performance measures, and I think that one thing that would be very helpful to the group, on the population indicator side, I mean that's obviously not just a heap of indicators, but there's a causal pathway there, of determinants and outcomes of population health.

In that causal pathway are the social determinants, the behavioral determinants and health care system determinants, that lead to the outcome, some of the outcome measures that you're talking about there. So I think helping us in the framing of that model of the causal pathway of indicators would be extremely useful. Then, where I get to the struggle of sort of reconciling the framework, the performance indicators are measures of the components of that causal pathway.

So it's not a separate set of measures, that the performance of the two that you pick, the health care delivery system and the governmental health system, which we've broadened, I think, in our conversation, are elements of the determinants of health that we would want to capture in that causal pathway.

So I guess I don't see this dichotomy as framed here, and that the causal pathway for the population indicators would include the performance of the components of the

system.

MS. JACOBSON: Yes, I totally appreciate that comment. That was Matt, correct, and I think that is the brilliance of Mark Friedman, and I can't believe he's still in relative obscurity, you know, as far as sort of being this measurement guru.

We can work on a way of sort of definitely showing the linkages between sort of upstream determinants, you know, the actual sort of then behavior and outcome definitely, and what I would like to propose that we could try to do for you is show how interventions then influence stuff in that causal pathway.

I think this is one of the biggest areas of confusion within the public health community, is we'll move an intervention, which is policy creation, and say it's a social environment measure. By creating a policy, you either influence the health behavior and environment, or ultimately a disease and a causal pathway.

But I'd like to step up to the challenge of seeing them separate, but showing you how these are really then levers, as Jackie was saying, levers that sort of dynamically are created and like influence behaviors and health, environment, behaviors and health.

DR. STOTO: So Dawn and Steve, this is Mike Stoto again. I'm sitting next to Matt, but rather than just talk to him directly, I agree that this causal pathway really is the critical thing. But I would say there really is a distinction between the measures on the left and the one on the right, and that the ones on the left are things that the community shares the responsibility for; that the ones on the right are things that one or more entities can be held accountable for doing, so that we eventually get to where we want to be.

MS. JACOBSON: And I think on the challenges, seeing policy development and

enforcement as an intervention rather than a social outcome. I mean it's tricky, but we can -- I think it's in the ten essential public health services and accreditation demands, which I know everyone on the Steering Committee's familiar with.

But does that help Mike? I mean these things are sort of like surveillance is an intervention that leads to improved health.

MR. STIEFEL: Yeah, right, I mean I agree with that, that you know, somebody creates those policies. I could be the City Council or something like that. Those are parts of the community that intervene to create health.

DR. JARRIS: Andy.

MR. WEBBER: This is Andy Webber with the National Business Coalition on Health. I thought the presentation was great, and I actually like sort of how we framed this.

I'm a little concerned about the scope of our activity, I mean we've obviously

said, and I think we're in agreement, that we want to get beyond government public health and providers.

But I mean we could put together a very long list of entities, organizations, where we would like to develop performance measures, you know, ones that are really focused on that individual entity or shared among different entities. So I wondered, just to give Dawn some guidance here, do we need to put some parameters around that? I mean you know, we've mentioned employers, we've mentioned transportation systems, we've mentioned, you know, public health. Do we need to identify them all here?

DR. JARRIS: I think we're still in an early phase of trying to discover how we're going to scope this. So I think it might be premature to do it now. But we are perhaps in the phase of creating confusion, as opposed to reining confusion in.

But I found at least like some of the

other groups, it was typically when we hit that point of there is no answer to this, that some breakthrough thinking came through.

So let's expand it a bit now. We will, what's probably important is what are the important measures of population health, and then secondarily to that, and then therefore who would be accountable for those things, as opposed to starting out with the accountability.

I think one of the, as a distant observer to some of the other NQF processes, one of the issues that's been faced over time is you may have one measure for, you name it, surgical site of infection or some other, and yet one objective to measure that.

But there's a different one from physician's office, from an ambulatory setting, from a hospital setting, from a nursing home, and we certainly want to avoid that.

So the issue to me is what's the

important thing to measure, and then later, who has responsibility.

MR. TEUTSCH: Could I push back a little bit on that, because some of the -- as you link sort of what are the resources and capability that can then be used to implement various processes include some various intermediate and long-term health outcomes, if you look at the proximal side of this, which are the resources and capabilities, you can look at, whether it's the education system or the employer or organized public health. But it often is the people who are actually making decisions about what those allocations should even be, the politicians and the other leaders who are making those choices.

So we do have to figure out a little bit where the accountabilities are actually going. Who is going to be making these big allocation decisions about health care versus public health versus education, versus taking the transportation money and putting it out

into safe streets and complete streets.

These are very upstream kinds of accountabilities. If we look very much, you know, at specific interventions in specific things, we're going to get to different types of measures and different kinds of accountabilities. I think it's one of the things that we've got to wrestle with if we're going to not only bridge these population in clinical areas, but then figure out how we're going to get the right resources to bear on them.

MS. JACOBSON: Yes. I often say in my measurement work, if decision-makers, and I mean that loosely, whether it's organizational, political, you know, health care or otherwise, if some decision-maker would just say we're looking at the data and there's four leading behaviors, it's the whole 3-4-50. Three diseases or the three risk factors that lead to four diseases, that lead to 50 percent of deaths.

If someone were to say as a nation we're just flat-out going to fund that and do that, it would all cascade down very easily. Of course, it doesn't happen. So we're left with we could take the four leading behaviors and really integrate this for you, and show how it would fit into this framework and be very useful, I think, over time.

And depending on the issues, for like physical activity, that would bring in probably all the public health system partners, you know, over time. For tobacco, maybe the same thing.

You know, I guess it's sort of the chicken or the egg. To me, it doesn't really matter where we start. Just know that if we start with system partners and what their specific priorities are, we're going to end up with 1,000 indicators to measure.

That gets back to the scope of which no organization can, you know, expect them to track and improve 1,000 indicators, you know,

of organizational performance or public health, population health and performance.

When I sit with managers and talk through this, they're like oh, it's easy. We're just going to improve, you know, chronic disease. That's 100 to 200 indicators right there of population health improvement that you could pick. What are your priorities, you know?

So it's really, it's harder to go from not bottom up but system back to priorities. It's easier if the National Quality Forum and the Committee would just pick four, five, six of your own winnable battles, you know, whether they're freedoms or not, and use the framework to show how it's integrated and cascades down.

DR. JARRIS: Okay, thank you. Bobby, did you have a comment?

MR. PESTRONK: Actually, I'm not sure if I do. I think, Paul, your observation before that starting from outcomes would be a

useful way to work back. I think that what's just been shared is sort of along the same lines, and I'm struggling myself with whether it makes a difference where one starts, so long as one gets started.

Then the last thought I have is the present analytic frame for this, which I like as it's described here, but it starts from documents that are already in the context of the U.S., and I understand why one would want to do that, because we're in the U.S. and we're trying to influence the U.S. system, and so it's a question of starting where we are.

The question I have is whether it might be useful to start from documents that have been produced in other cultures, because they'll tell us something different than what we already know, and it would give us a completely different place to start.

I don't know whether that's a good idea or not, but I'm struggling with whether when we get this, we're going to -- on the one

hand we'll have, if it's framed in the way it was just framed, which is okay, here's I won't say winnable battles, because that says it's these five or six things.

But if we pick a couple of outcomes, then what we're saying is okay, we're going to try and walk back into the existing system and define what everybody needs to do, which is kind of what everybody's been trying to do for the last 20 to 30 years. The other approach is to say how we really want to do this differently, and what does it mean to do it differently.

The only way to learn how to do it differently is to look at somebody who's doing it differently and see how they went about doing it. Does that make any sense to anybody? I don't even know if it makes any sense to me.

DR. JARRIS: Yes. I personally think the 37th in the world is good enough. One other thing, and we're out of time, but just

for Dawn and Steve. We also have to look at this concept of what do we mean by the term "community," because it's another word that means so many different things, and we may not come up with one definition, but at least quantify or qualifying it, so we know when we use the word what we're talking about.

Is it a geographic block? Is it a county, is it a state? Is it a type of person, based on socioeconomic, racial, you know, disease, whatever it happens to be. But we need some better definition around the word "population" and the word "community."

We are out of time, so we probably, we were supposed to have a period now where we have public comment. I'll ask NQF staff how we will do that, and we welcome any public members who may be on the phone or in person.

MS. MUNTHALI: Operator?

DR. JARRIS: Thank you Steve and Dawn very much. We'll be back in touch.

MR. TEUTSCH: Thank you. We'll look

forward to working with you.

MS. MUNTHALI: Operator, Anthony. Public Comment

OPERATOR: I'll open up for public comment at this time.

DR. JARRIS: Is there anybody here who would like to make a comment who's in the room in person? Peggy, come on up and we have 15 minutes. So I guess we'll give you two minutes, Peggy.

MS. HONORE: In 2008 --

DR. JARRIS: Tell us who you are, for the folks on the phone.

MS. HONORE: Oh, sorry. This is Peggy Honore in the Office of Health Care Quality, in the Office of the Assistant Secretary for Health, Howard Koh.

In 2008, in that office, the Office of the Assistant Secretary of Health, we embarked on a very pioneering effort that some of you in the room participated in, and that was the establishment of the HHS-wide public

health quality forum, with input from all of the major public health stakeholder organizations.

What was produced at the time was a consensus statement on quality in the public health system, that laid out the nine consensus aims for what we considered is what should be characteristics of quality, when performing a public health mission. Not by a governmental public health agency exclusively, but what should be the characteristics of anyone contributing to that system.

We also defined public health quality. We had a follow-up convening in 2010, where we established priority areas for the improvement of quality in the public health system. In designing this project with NQF over the last two years or so, we very much had in mind that those initiatives would be folded into the conversation in some way, in the design of whatever is going to emerge.

So I appreciate Ron Bialek's mention

of those this morning, and we very much would appreciate those things be considered as this process evolves and deliberations continue.

DR. JARRIS: Thank you, Peggy. Anyone on the line? Anyone else wishing to make a public comment?

(No response.)

DR. JARRIS: Okay. I think that would conclude that section, and next on our agenda is a lunch break, which looks like it's about ready. I'll turn this over to people who know what they're talking about.

MS. MUNTHALI: It looks like we have to give the hotel staff about five minutes to set up, and then we'll have lunch and we'll reconvene at 1:00 p.m.

DR. JARRIS: Go ahead, Matt.

MR. STIEFEL: I'll take advantage of the five minutes. Just very briefly, back to the framing for the report. I think one thing that would be useful is to clearly distinguish between health outcomes measures and health

determinants measures. I don't know that we've been clear about that so far, and even in looking at the measure evaluation criteria.

I think there are different criteria for measures of health outcomes and measures of determinants of health. When you're looking at length and quality of life measures or disparities, the criteria for measurement seem very different. They seem very different types of measures than when we look at the behavioral, social and health care determinants of health.

So I think the background paper would be very useful in helping us to distinguish between those two different types of measures, how they fit together, and how they differ from each other.

DR. JARRIS: Very helpful. Ron.

MR. BIALEK: This might get into this afternoon's discussion or even tomorrow's, but when I think of measures, in terms of selection of measures as what's the right

measure, right, what has impact and what can have impact, but then I also think about who's going to use it.

I've been thinking all morning about that, which is we can come up with lots of right measures that if applied would have great impact. But I'm not really clear on once we complete our work who the target audience or audiences are for the measures that we will be selecting.

It would help to have some clarity on that, because that should, I think, go into the thinking about what we choose.

DR. JARRIS: Well, you know, we should ask Helen to comment on this, because the other thing it's my understanding NQF doesn't develop measures; they endorse measures. So can you answer?

DR. BURSTIN: I think it's a great question. Again, NQF doesn't develop measures. We really just are the neutral convener and evaluator of measures. So once

you guys set the standards for what those should look like, we'll do a call for the measures hopefully in those prioritized areas. We don't always know what the uptake of endorsed measures will be. They do tend to get picked up for accountability purposes, and again, this is such a new space.

I think the real question would be, you know, might some of these get picked up by broader, newer entities like ACOs? Might communities or states looking for measures pick these up for accountability? I think it's a really good discussion, and I think it's part of what we framed for this afternoon.

DR. JARRIS: Any others? So I think ACOs, should they ever get off the ground, would be a very nice target, because you know, potentially if we can create it, they'll be held accountable for both cost savings and quality.

So if we can create some population-

based quality parameters, they can then be held accountable for what's the incidence of obesity or the incidence of diabetes, so just what's the A1C.

The other area this could be helpful in is the community benefit that the non-profit hospitals have to develop, based on new IRS regulations. If we have some quality measures, perhaps they can start being held accountable for community benefit that's a more population level.

MS. MERRILL: So if we were to follow these characteristics of quality in the public health system as our guideline, we would say ostensibly call for measures that are risk-reducing measures. So that we would have to come up with some criteria for what is risk-reducing, and then that could be applied broadly across different areas.

So what is risk-reducing for obesity? What is risk-reducing for smoking? Is that --

DR. JARRIS: I think we're going to

have to keep looking. It seems to me it's a set of principles, and as we work, we should be informed by those principles, and when we're done, we're going to pull them back out to say have we missed anything.

MS. MERRILL: But we have to refer back to -- so when we're creating measures at this level, or when we're asking for measures at this level, somehow, if they're going to reflect quality for public health or population benefit or all these other terms that we're considering, we must have some way.

These must be some criteria somehow involved in that, the same way we've got impact and gap, performance gap. We have to have some kind of risk-reducing criteria. See what I'm saying? So it's not just performance gap. If it's quality and public health that has to have risk-reducing component. I'm getting nitty-gritty maybe.

DR. STOTO: This doesn't relate exactly to what Jacqueline was saying, but to

the point before that, and it brings us back to this idea that somebody said earlier, we may have these thousands and thousands of measures. So I think that maybe one way we can think about what we're doing is thinking about a framework for which specific measures can be -- within which specific measures can be developed.

Well, what I would say is, going back to what Matt says. You know, we need to think about this logic model. How are -- is what we're doing going to eventually contribute to the health of the community? But we may be talking about what's the ACO going to do in that context? What's the health department going to do in that context? What somebody else may be doing in that context?

Not expecting that the ACO will do everything that needs to be done to inform the healthy community, but what can they do in that context? How does it relate to the goal that you eventually want?

DR. JARRIS: You know, some of the discussion about accountability, like for example, would the ACO actually be held accountable? It reminds me of the early discussions with the physician groups around quality measures, and their response, I can't be held accountable for that. I don't control it.

Well, nobody controls anything. I've got teenagers. So it's, but they can be held accountable for being at the table and being involved in the conversations.

MR. COHEN: And that's good, in terms of the question I was asking before, which is that we really need to be clear that accountability needs to be shared, but that we start to tease out what at least we want to look at as the part of accountability for different sectors or different players, and you know, in particular what is the health care accountability, which I think then flips, in terms of some of the patient-oriented

measures as well.

For example, I think that if we have a patient-oriented measure, where part of it is someone is not saying what are the community factors that are changeable, that are leading to it. Someone's coming in, for example with lead poisoning, and you don't ask abut the community environment, but you just treat the lead poisoning.

There have to be measures that say that's unacceptable, if we're concerned about population quality. You know, I actually don't like logic models, and I really like the comment that Dawn made earlier about simpler is more elegant. But I do feel, and I don't know how exactly how it fits into the afternoon's discussion.

We're talking about 15 or 20 different documents and national initiatives, and I feel like in a way we should be building, using all those as building blocks and as resources for us, as opposed to saying

"oh, let's look at one or another and basically have the same level of conversation. I don't even understand what they will all are or what their contributions would be.

But I feel like, and I think particularly some of the people from the federal government, understand at least many of those better. But I feel like as part of moving this agenda forward in the most effective way it would be helpful, and I don't just want to turn t his over to LA, because I think it's unfair. I don't know what level of resources we're giving them, but I feel like we're asking for a huge amount, and I hope they can provide at least some of that.

I feel like in a way it would be helpful to delineate what all these different efforts are, you know, categorize them or cluster them in some way. How do we put them to use? What answers have they already provided in terms of outcomes or the kinds of data associated with outcomes?

For example, we talked about the prevention strategy this morning, and I brought it up on a few occasions. I know they work very, very hard on outcome measures, to come up with population-based outcome measures. I don't have those at my disposal, but it seems to me that as a group, that would be one of the places we'd most want to go, to population-based outcome measures, because they include 17 different federal agencies.

They're looking at transportation, they're looking at agriculture, they're looking at economic development, and us kind of proceeding in the wilderness, without all that information at our disposal, you know. It feels like we need to be, move the agenda forward using every tool we have possible.

DR. JARRIS: A new Ph.D. thesis is born. No, it's very important. You're right. If somebody can do a table or cross-walk that for us at some level, it would be so helpful. Michael, is that? Okay. So why don't we take

a lunch break and be back at 1:00, which I think is when the big hand is on the 12 and the little --

No. Let's really try to be back here at 1:00 if we can. Thank you.

(Whereupon, the above-entitled matter went off the record at 12:34 p.m. and resumed at 1:09 p.m.)

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

1:09 p.m.

DR. JARRIS: Okay. So it's a little after one. For the afternoon, the next couple of hours, we're going to have some discussion, and then finish off the day, I believe at three o'clock, on picking a few of the measures to take a look at, for the purpose of understanding the process, learning the NQF methodology as a basis for us then to look forward to how do we extend that beyond clinical measures into perhaps behavioral and community health measures, and there will be some of the methodologists calling in, I believe, on the phone, to help us with that.

I believe we'll start with immunizations, which might be an easy way. Is that true?

MS. MUNTHALI: Yes.

DR. JARRIS: An easy to really look at not only the clinical, but think about behavioral and population health, since I mean

there are certain states where nearly all the vaccinations in the state are given by the state health department down south. So they might wonder what the clinical role there is, for that matter.

So first all, some housekeeping. Reva, did you want to talk about dinner for tonight? Oh, I'm sorry.

DR. WINKLER: Oh. We just wanted to remind everyone, if you're interested in having dinner with your colleagues tonight, our colleague Sheila Crawford is outside, and she will make arrangements. So just make sure you stop by and see her.

DR. JARRIS: Okay. So an important question, I think, for this next section, discussing population health measures, is what is the outcome we're seeking? What is the product we need to develop when we're all done, finished and done? So we thought we'd ask Helen to speak about that a little bit, so we can keep the end in mind.

DR. BURSTIN: Great, thanks. So our end goal is obviously is to think about bringing in what you would view as high priority population health measures that we can bring in for endorsement in the second phase of this project.

So part of our goal today has been, for example, just have at a little bit of an initial review of our evaluation criteria and think about how those fit the discussion we had earlier about our definitions, perhaps, of population health.

But I think the issue for us now, as you kind of face this next set of questions, is if our end goal is to get to a set of endorsed population health measures in some prioritized areas like obesity, smoking and physical activity, we need to write that call for measures essentially.

What are we going to ask the broader measurement community to respond to? What are we going to ask them to submit? Once it gets

to us, how are we going to evaluate it, which is why we'll return to the discussion we had this morning, after people have had a chance to, I think, reflect on some of our reviews of the measures this afternoon.

We want to be able to call for a set of measures, and we need to be able to be crisp and explain what we mean. We've already done some of this work, and it might be helpful. It hasn't been done in a way that has allowed us the luxury of having this very thoughtful foundational work first.

But for example, Reva just led our child health quality project, where we all endorsed numerous measures at the state level, for example. There's a low birth weight measure, for example, that is a state level of analysis.

There are multiple measures that came out of the National Children's Health Survey, that got at issues like missed days of school and some of the more classic population health

measures that currently have only been able to have been analyzed to the state or community level.

So we've already done this. We've brought in many of the AHRQ prevention quality indicators, for example, the preventable hospitalization measures that are supposed to reflect community capacity for primary care.

So we've gone down this path a bit, and I think what we'd like to do with this is be a bit more purposeful as we go into this next phase of work and help you have us write that call in a way that brings in the measures you're going to want to see put out there. Does that help?

DR. JARRIS: So one thing you said that I heard you say is that the scope really or that is around tobacco, either towards tobacco, obesity and physical activity. So is that in fact where HHS is funding NQF, or where NQF intends to have these population measures focused around?

DR. BURSTIN: We have had discussions with HHS about what they thought were the prioritized areas, and those seemed to rise to the top. Again, that's not set in stone per se. If there's obviously something we've left off that you think would be really important.

I think the concern was this is such a different area. We should do this in a way that we have confidence that this is the right foray. Will we learn from it? Might we do something different the next time we call for measures?

I think, you know, this isn't our first and only, you know, attempt at looking at pop health measures. I think this will be hopefully the focus of all of our projects going forward. I mean ultimately what we hope is sort of like the way, you know, two years ago we did a framework for how to evaluate composite measures, and brought in composite measures to that project.

Now all of our measures bring in

composite and individual level measures. I think in the same way, we're starting to think about in two years, when the cardiovascular measures are up again, how would the call for measures look different? What kinds of measures do we bring in that won't have that more narrow clinical view you'll see today, but how do we get that broader expanse?

So it's not just a one-time project. Our thought was should we pick a few areas for this project, get our feet wet, see how it goes, and then really move on to standardizing this into every project we do.

DR. JARRIS: Just for clarification, were the words "tobacco, obesity and physical activity," or "tobacco, nutrition and physical activity"? I'm just curious.

DR. BURSTIN: It was not that precise. I think it literally just said smoking, physical activity and obesity. But again, I think there's a lot of degrees in there. We just thought it would be helpful to

have three areas. Whether those are the right three. We know the other advantage of those areas is we are trying to get somewhat at that Venn diagram.

Those are also areas where there are clinical measures. So we thought it would be interesting to have the opportunity to have a project where we could actually try to harmonize some of those concepts as well.

MR. MASON: So there's no plan to just go through the existing clinical measures, and add or look at it from a population health component, as opposed to calling for all brand new measures? That's the first question.

DR. BURSTIN: We will, as part -- our expectation is, at least in those three areas, we will look at the clinical measures in those areas when we're looking at the population health measures. We already have measures in some of those areas, both for new and existing.

So for example, Joint Commission just did a whole new series of smoking measures for hospital. It would be logical that we look at those in the broader context of whatever comes in in the second phase of work. So it won't be that there's an expectation that the population health measures just have to be an aggregation of the clinical measures, but we also want to have that opportunity, and this came up this morning, to make sure that one set of measures is not put at a disadvantage or, you know, that one has to lead the other necessarily.

MR. MASON: And then the second component is you said that the cardio measures aren't open again for another two years, and one in three. So heart disease and stroke, the biggest killers. Two years seems like a long time to apply population measures or population aspects of a measure, if indeed that's one in three on killing U.S. citizens.

So I wonder if there's an opportunity

even to re-look at that, to say hey, we just got done redoing cardio, but two years is way too long. What work we do in here is really going to have an impact, and cardio being a great place to do that.

DR. BURSTIN: All those things are certainly open. We just have our usual schedule where we know we're going to look at all the measures. That's a certainty. If there's other opportunities, we'll try to meet them. I think that was also the logic of the ones we chose. They're obviously a huge impact on cardiovascular disease as well.

DR. JARRIS: I suspect if we wanted to have population measures in cardiac disease, we'd have to start now anyway to catch back up in two years.

MR. STIEFEL: This is a refrain that will probably begin to get annoying to other Committee members, but it's about again, the distinction between determinants and outcomes. Smoking, nutrition and exercise are not

measures of health. They're measures of determinants of health.

I'm just curious if the charge to this group is about coming up with measures of health. It's an important question, because I think if we start with measures of health and health outcomes, that is, in my mind, the appropriate way to frame the work, to go back to those things that have the biggest influence on health.

But starting with the things that have, that we think are the determinants, leaves a gap, at least in sort of the model that we're trying to use.

DR. JARRIS: Larry was next, and then --

MR. COHEN: I mean I think I want to build on that point, because as I said, I think if we're thinking about where we want to get and how to measure what we want to get so the outcomes are right, from my perspective as I've worked in community health prevention and

equity work, we end up with community determinants.

One of the things we've discovered is often a good solution solves multiple problems. So for example, if we talk about an issue like walkability, you know, we're talking about health. We're talking about physical activity; we're talking about safety at the same time.

I mean in terms of lives, clearly we're talking about chronic disease. In terms of years of potential life lost and some of the broader equity issues, I think we have to talk about chronic diseases, and that would include asthma at times, because I think there's enormous opportunity there, and we also have to talk about injuries.

So I guess I'm questioning a little bit the assumption, and I definitely wouldn't talk about obesity, I'd talk about healthy eating. But I'm questioning the not necessarily that it's the best place to start,

but that there could be better thought about whether the best place to start is automatically healthy eating, active living or even physical activity and tobacco, or whether there are a couple of other things that are just as compelling.

But from my mind, a broader definition, if we're going to talk about population health, that doesn't say that that's the determinant, but really looks more broadly at what, you know, what the underlying determinant. You know healthy food in stores, for example, takes in healthy eating and tobacco at the same time.

MS. MERRILL: You're actually starting to respond to these criteria, because these criteria are actually saying those kinds of things, do measures kill more birds with one stone. That's kind of what this is, in a, you know, in a more equitable proactive way.

DR. STANGE: I just have a question for Helen that's kind of a follow-up to Matt

and Larry's question. In your talking with HHS, because there is some overlap in the framing between certainly the obesity and physical activity frames, do you have the opportunity to go back to them and say you know, we decided we were going to choose two of those three or lump those in some way.

Because those have the advantage that they have clinical measures, but we might choose one that really is more something that would be a health outcome, that would be different that way, and that maybe might not have any corresponding clinical measures, and just see what we learn from that, to maximize our learning. Is that something that's possible?

DR. BURSTIN: It's certainly possible. Yeah, I think it would also be helpful for me to actually have Matt or somebody, I think to make sure again, we're all talking about the same things. It would be helpful to actually try to distinguish what

are determinants versus a health outcome.

I think actually a few examples of that might be -- I'm not sure we're all thinking of it in the same way.

DR. JARRIS: Yes, because when you said "determinants," I thought of social determinants, not proximal measures for outcomes. So there's another language.

MR. STIEFEL: But we've talked about the notion of this causal pathway between determinants and outcomes, and you can think of the social, environmental, genetic factors leading to behavioral factors, which lead to physiological determinants, which lead to disease factors, which lead to functional status, which lead to quality of life, in an intricate sort of causal pathway, that has feedback loops and the rest.

But I think just important distinctions between those things at the right-hand side of that, that have to do with life expectancy and quality of life, and the

distribution of health in the community, versus those things that affect or determine those outcomes.

DR. JARRIS: Go ahead, Mike, before you explode.

DR. STOTO: Yes. So I think that the causal pathway is the way to think about this. But I'm not unhappy with these obesity and activity and nutrition, because they are, in a way, the result of the different kind of activities, that different health care sectors, other sectors, public health do.

So I think if you want to make a distinction between the activities that we, different parts of the health system do, and the results that come from that, it's okay, and these are three things that people care a lot about, even though they may not be the ultimate goals. They gather attention. We can then think, you know, how can the different entities within the broader health system make a difference in those?

MS. MERRILL: Is anybody else an informaticist on the panel, because I'm just thinking of an informatic solution that might help us. So informatics is involved with knowledge management. So basically what we're talking about is concepts that have parents and children, right.

So some of these -- so when we talk about some of these bigger ideas, the idea that something could be the parent of a number of different children health conditions.

So like you're saying the walkable environment, actually children of that, outcome measures of that would affect cardiac, obesity, work life. You know, so it would be a variety of things, all going up to one, sort of in a hierarchy of conceptual framework. Do you understand what I'm saying?

It's because there's such an overlap involved. Some of these measures, they would all sort of stem up to the same idea.

DR. JARRIS: I think we, considering

who our audience is, that both NQF and I would even say many of the components of HHS, are very clinically-oriented. So if we can frame something in terms of, you know, major underlying causes of death, tobacco, if you want to call it obesity or nutrition and exercise, I think they'll get that.

If we lead with walkability, they'll say where's this come from? I mean I still think if we talk about these three things, walkability is going to be a clear measure with many cascading benefits to it. But at least it's in a context that will be received.

MR. COHEN: I agree with you. I do think, though, there's a question about short-term change versus making statements that promote the kind of change we really need to see in this country.

I'm fearful of continuing to go with the status quo at a time when our health care is really, really struggling, and we have virtually no prevention and continuing to

affirm the old way of thinking.

DR. JARRIS: So the first question for this afternoon is what is a population health measure, and I think that we're getting into that. So one way of answering that question might be a population health measure is one that's set in the context of a causal pathway, that will connect the actions of different entities, including health care providers and others, to population health outcomes that we're concerned about.

So some of the things that we do, like the prevention measure we'll be talking about later, if seen in that context could be seen as population health measures. It's just a way of framing the issues maybe.

MR. PESTRONK: Will we have at some point a, and I don't know whether the LA document is going to do this, we all have different ways of wanting or thinking about framing what the group is going to do, and how it will approach its work, because we're all

coming from different points of views and frames.

Even when we're talking, as we said before, using the same language, we're still talking about different stuff, different things, or understanding it differently. Is there any way between now and some next meeting, to lay out the alternative ways in which this might be approached, so that we could reach consensus on the approach that we're taking here? Rather than starting down a path, without having had the opportunity to decide, though, that's really the path that we want to move down.

I'm thinking, so that's the first thing. Then I'm thinking about the HHS consensus statement on quality in the public health system, and asking myself how does that apply?

Is that the set of metrics that we should be using to determine whether any measure, in addition to the frame that NQF

usually uses, which Helen, is what you were describing earlier, is that another lens to which we should be looking at any measure that we pick, that it fits in one or more of those categories, because HHS has already consensed around those being the aims for the public health system?

If they have, then there's already consensus. So we ought to be using it and promoting it.

DR. JARRIS: Well, the corollary to that would be do the clinical measures look at the five attributes, the safe, effective, patient-centered, dah dah dah, and I don't know that it does. But specifically, do they?

DR. BURSTIN: Everything will track to essentially the National Quality Strategy or previously the aims of the IOM. So yeah, we do specifically look at measures in each of those buckets, yes.

DR. JARRIS: I'm sorry, Madeline. Go ahead.

DR. NAEGLE: I like those three areas for a lot of different reasons, because of course they address measures of mortality. But I think there is a lot of overlap with previous work that's been done, and I would agree that we are not as well-established as we would like to think we are in the area.

But in smoking and performance evaluation for smoking cessation, where we need to be certainly. And in the area of exercise, there's a tremendous amount of work which has appeared in the research literature, which is not getting translated at all into performance evaluation standards.

I really think there's some important work that we need to do there. Being new to the process, I'm still struggling about where we look at outcomes versus determinants. I liked what Michael said about does it really matter, as long as we set it in that causal pathway.

DR. JARRIS: So the other way to look

at what we're doing is in a sense, it's a proof of concept. NQF hasn't done this before. So the smoking, I'll say obesity and exercises; it irks me. I'll say that instead of nutrition and activity, but those are things that are clearly understood. They are major underlying causes of death and disability in this country. They also, tobacco's a pretty clear example of how alignment of the public health and clinical sector actually did something important.

So it's a really good one to pick as a proof of concept. So you know, and the same I think with physical activity and nutrition. Clearly, there can't be a greater need in this country. We haven't yet gotten to the same place, where the case is as clear as it is in tobacco about aligning public health and clinical medicine, although there's a lot of good work going on there now. So that's a little bit more of a stretch.

So those three things may be a very

good proof of concept, so that NQF and HHS comes back and says yeah, this makes sense. Let's broaden how, you know, the areas in which we do this. Matt and then Linda. Larry, is that just a standing? I call on you every third person. Okay, you can put it down.

MR. STIEFEL: It's just a small point, but just in our conversation, people speaking in support of smoking and nutrition and exercise argue that those are good measures because they're major contributors to death and disability.

So that mental model suggests that death and disability are the population health outcome measures that we care about, and that smoking, nutrition and exercise are along the causal pathway, determinants of those outcomes.

So you know, perhaps -- I mean I agree. They're important measures. But I think we at least need to have the discipline

of saying this is our framework. These are the population health outcomes, and even in people's language, in this conversation, it's death and disability.

So the question that I still have is where are death and disability, or functional status, in this framework, and how do we make that linkage in the causal pathway, without just jumping into smoking and nutrition?

DR. JARRIS: Do you have a suggested answer to that question?

MR. STIEFEL: That we have outcome measures, as well as these measures, and if what we're saying underlying why we believe smoking is important, is because we believe death is important, then death may be a measure of mortality or mortality amenable to things we can fix, is a population health outcome measure that we start with, and then we say we're going to focus on smoking, because smoking is the biggest improvable contributor to that.

DR. JARRIS: Rhonda, I don't know if you recall, but the United health rankings, and this may not be your area, but there is a measure that is used for years of preventable life lost or something like that, and it's actually looked at among different populations, African-American, Caucasian-American. So is that the type of thing you're talking about?

MR. STIEFEL: As a measure of mortality, yes. It's years of potential life lost, I think. You start, you know.

MR. WEBBER: The LA discussion this morning, I think Matt talked about health status indicators, and then having performance measures that are more on the causal factors of contributing to that indicator. Then so yeah, I do think we've got some terminology issues here.

DR. JARRIS: I believe Linda was next.

DR. KINSINGER: I'm not sure where

this point fits into this discussion, but I was just going to make the point that I think an advantage of looking at physical activity and nutrition is that those are areas for which there's really less clarity about the role of clinical systems, and they're probably much more addressable at a community or population level.

So I think those two particularly really do stretch things more into that side of the, you know, the picture, because while there are clinical ways of addressing them, they're probably less effective overall than, you know, than non-clinical ways of addressing those issues. So I think it really does help to move things into that direction.

DR. JARRIS: And I think it's bariatric surgery centers per thousand population is the measure, yes.

DR. PICKENS: Well, we mentioned it earlier this morning, the work that RWJ has done with accounting health rankings, and you

mentioned it briefly. They have that, you know, policy is the base and it's sort of a cyclical policy, health risk factors that include the social determinants.

So what he's talking about as a determinant are actually risks to the outcome, which is mortality, quality of life and years of potential life lost, or I think they actually use quality life years lost, which is different.

MS. MERRILL: So can I just bring this back to what we practically will have as our outcome? So say we decide on this framework, and we call for measures. Who would be submitting measures and what would that mean? So in other words, would we come up with our framework, call for measures, and then Kaiser Permanente would come and say we want to rate ourselves on one of these measures?

Is what we are saying practical for the people who are invested in getting

measures from NQF? So how would a Kaiser Permanente use a population level measure?

DR. BURSTIN: I think it could be used at a lot of levels. I'll let that answer that. But I think it could also be used at the community level. I think that's the point, is we're trying to get out of the box of it only being a healthcare --

MS. MERRILL: I'd just like to see, you know, have it explained, so that we could make the links. That will help our thinking.

MR. STIEFEL: Well, we could, but I think it goes back to the important conversation we had earlier, probably when I was talking about the evolution of the Triple Aim, IHI's Triple Aim, is that single entities joined Triple Aim Collaborative and quickly realized that single entities couldn't achieve the Triple Aims.

So if we're talking about population health outcomes, Kaiser Permanente can't do it alone, and needs to participate in a broader,

multi-stakeholder collaboration with schools and employers and public health and social services and the rest, to achieve these outcomes.

MS. MERRILL: So you would select a measure, and then get some measurement with your partners?

MR. STIEFEL: Yes.

MS. MERRILL: And then you would say we have reached this level of measured population level performance with our partners.

MR. STIEFEL: And that we could measure our contribution to the determinants as performance measures for our organization. So you know, I think it's in that causal pathway, where the healthcare organization can contribute, would be a performance measure as well. That's a determinant performance measure, as opposed to an outcome.

DR. JARRIS: So then the Communities Putting Prevention to Work, which is part of

the American Recovery and Investment Act, did fund around 50 communities to look at tobacco and obesity, and that did require a large consortium being put together. There was no, as you said, no single entity can deal with those issues at the community preventative level.

So there is some experience. The evaluation of that is ongoing, although I've heard the evaluation may not obviously turn out to be quite what's expected. It's hard to prove these things. Mike.

DR. STOTO: Two quick things about the focus on smoking, obesity, nutrition, whatever. One is from the proof of concept point of view, those are areas where the evidence is pretty good for the kind of non-clinical, as well as clinical intervention. So that's another reason for starting there.

The other thing is, another reason for kind of starting there and not ignoring these outcomes, but focusing on measures of

those things is because sometimes, say take lung cancer, that's the result of smoking, you don't see changes right away because of the latency period. But you see changes in the smoking behavior sooner, and I think that's a useful property of remission.

DR. JARRIS: Sarah.

MS. SAMPSEL: I think I wanted to build upon Matt's response a little bit, because I think health plans are looking for this type of measure for a number of reasons. One is resource direction, and you know, health plans either have a foundation or other mechanisms that we're working in communities.

In order to evaluate our efforts in the communities, we need to look beyond our membership, and in order to do that, we need some kind of public basis for measurement, so we can say this is how we're tracking, when it isn't our internal data.

So I specifically run an entire health index off CDC data. Not ideal, you

know, sometimes due to periodicity, sometimes due to, you know, just other data aspects of what we get out of our public health system.

But we need something like HEDIS for the public health side, and then, you know, and exactly what Matt said, is there has to be a way to evaluate our efforts on each of these essential areas of population health or public health or health determinants, that aren't out there right now.

And even the existing measures in obesity and public health, I mean, they're very much down the road of did you measure BMI, not what is BMI.

DR. JARRIS: Larry and then Kurt.

MR. COHEN: I was really interested in your comment, Helen, about that communities could respond to these issues, as well as medical institutions. The first question that came up is how would they know about them, why would they be interested in responding, why would this in any way feel relevant to them.

I feel like the comments about Kaiser's partnership in CPPW provided at least some of the answer that I think we really need to think about, if we're going to move this constructively, which is that the best way to reach them probably is through linkages, and to really then think about what's going on in those community benefit efforts of Kaiser, for example, or in CPPW or soon in community transformation grants, and how do we align with that, and with that way of thinking.

So for example, the word "obesity," which probably brings up BMI notions and, you know, certainly kinds of goals, versus the word "nutrition," versus the word "food system." Food system of the three is the furthest from the medical side.

But in some ways, it's going to bring up the most constructive community solutions, because food system will then talk about the work Frank and I were discussing earlier in Philadelphia, of you know, using economic

development dollars to increase the number of supermarkets, which has now been adopted by the Obama administration and it's going nationwide.

You know, in that case it may be kind of tied to obesity, because obesity has kind of become a national theme. But I think we have to consider very carefully what frame we're looking at, because I personally don't want the frame to be measurement of BMI.

I think that's a terrible mistake which has misguided community, because it leads people very much to an individual solution, and we already have a medical individual paradigm. In order to make community-wide change, thinking again about the fundamental question of what outcomes we want to achieve, you know, I think we have to flip that.

But I do think that the partnerships and the work going on there may be really instructive to us.

DR. JARRIS: Kurt.

DR. STANGE: I wanted to ask Andy a question. If we take Matt's idea of thinking about outcome measures in addition to these determinants of health process measures, what would be measures that would be engaging to the business community?

Helen gave an example actually of one that was about missed school days. So something like missed work days would be relevant for employed people. But I'm thinking even beyond that, like in Cleveland where we have less than half of our students graduate from high school, we don't have a very prepared workforce.

Is there something that could be measured as an outcome measure, that would engage partners that we don't currently have at the table, just thinking about the clinical systems and the public health systems, the things that could engage other sectors of government, the voluntary agencies and

particularly the business community?

MR. WEBBER: Yes. Well thanks. You know, I think it's the two levels, because I do think, you know, there is a defined population for an employer itself, you know, and that is their workforce, their dependents. You could create accountability measures for employers, working with other partners, including healthcare plans, Sarah, the provider community, community resources that could really impact the health improvement of that defined population, that a lot of employers feel responsible for.

In fact, they would say is increasingly a business imperative for them to be competitive. Health and productivity, workforce health and productivity improvement is related to competitiveness of their industry.

When you start to move into, you know, community-wide measures, I do think things like overall economic development

issues, things like the quality of the school system, again because in the minds of business leaders, there's a direct relationship there to, again, their enterprise and creating the conditions for them to be successful in a marketplace. I do think you can engage them at that level too.

So, you know, I think it's much easier right now, and we're seeing huge investments by employers in workforce health and productivity issues. It's a bit of a leap to get business leaders more involved in community-wide collaboratives, although Matt and others, that's exactly where our business and health coalitions are focused.

I mean, we've done a lot of work on worksite activities, and by the way, some measures on worksite activities, though, would be very useful to the employer community. You know, what is, what are the best practice intervention strategies for employers at the worksite.

But again, I think our larger interest here is to get community involvement at community level, employer involvement.

DR. JARRIS: There are though, in Iowa, there's a very large coalition organized by the business community. WellPoint is one of them, but then other non-health business community, to create a coalition to create healthier people. They're going after obesity, tobacco and other things like that.

So there are, as you said, they see it as a business imperative, and then Oklahoma City, the mayor has taken it on, a revitalization project designed to make walkable, livable communities instead of Target. I can't remember how many millions of pounds the people would lose in that city, and there's about 800,000 pounds they've lost or something.

So political leaders see it, business leaders see it. So I think there would be pretty broad-based interest in the right

measures.

MR. WEBBER: I think there are plenty of examples where actually the business community is taking a leadership role in community collaboratives. I mean, you know, one of our -- Jason just mentioned, one of our coalitions, Mid-America is in charge of the Healthy Community project and effort.

DR. JARRIS: So Jackie and Sarah.

MS. MERRILL: In terms of practical measures and, you know, users of these measures, so you think that the business -- in the same way that we have those LEED buildings, that a business would be interested in using an NQF criteria to be an NPP employer or something like that, that kind of a --

DR. JARRIS: You know, there actually is an employer wellness certification process like the LEED. It's called Health Lead, that has gone through an alpha testing. It's going through beta testing now with some major corporations. Andy's on the board; I chair

that board or that group.

It's funded actually largely by the private sector. Target's put in a million dollars a year to fund it. United has --

MS. MERRILL: Is there a public reporting capacity to it?

DR. JARRIS: It's a certification process for employers. We went through it as an alpha test, and I thought we were good. We got a provisional. So it is a really robust system around wellness, not just around -- because the hierarchy I see with employers, they first start out with how do we lower our premium, and then they start doing health fairs, and then they start perhaps doing disease management.

Then they start to develop comprehensive programs for their employees, and then ultimately, the most sophisticated ones recognize that their dependents, retirees are living in the community. Their customers aren't, so they actually branch out and reach

out to the entire community.

You have to be pretty high up on that scale to get the certification. So the process is in place. Sarah.

DR. LINDE-FEUCHT: Excuse me. Dawn mentioned this in her slide presentation, and also in the paper. But I'd just like to, you know, remind folks that Healthy People 2020 seems to be another big body of work, where there are targets on population health measures.

I know the Office of Disease Prevention and Health Promotion, where I formerly worked, I don't work there now, is doing a lot of work on implementation, and the idea is to get this down to the community level. So I don't know if that's another source where we could look for some population health measures.

Let me mention that they, you know, that work has all been based on social determinants of health, disparities and equity

issues, and it doesn't address just clinical issues.

But there are, you know, all kinds of things on access and other issues. I think worksite is part of that. So again, just something else that exists that might be helpful.

DR. JARRIS: So, you know, that's common. There are so many products out of HHS that are released in parallel. So somehow we have to think about whether anyone in HHS could sort of do a cross-walk of all those things, or whether the LA group could, or whether someone has a Ph.D. student who could, because it's a huge body of work.

DR. BURSTIN: I believe Dawn has indicated to us that that's actually been part of what she's already been working on, is that cross-walk. So we'll make sure that's part of this paper.

DR. JARRIS: So it seems to me that there is some perhaps consensus around this

notion of whatever the words are, smoking, obesity, exercise were the original words used. I think we should pick the words we want to use, if we want to decide that's the place to begin. Forget the words. Is that the right, do people agree with that as a starting point? Matt?

MR. STIEFEL: I think if we have a model or a framework in which those measures sit, that describe influence on population health outcomes, just selecting them without explicitly articulating that framework, I think, would be very problematic.

DR. JARRIS: I think I'd call these topical areas from which to do the work within, not --

MR. STIEFEL: Well, but what I'm saying is, I think, something different, in that we picked these because of their causal influence on population health outcome measures that we care about.

I guess I would still be

uncomfortable with only selecting those determinants, without articulating the downstream population health outcome measures of mortality-related or disability-related.

DR. JARRIS: So the CDC, I don't know when they first publish it, but they do have a chart frequently referred to in public health sectors, where you have the leading quote "causes of death," you know, heart disease, cancer, stroke, diabetes and those.

Then they have the underlying causes of death, of which tobacco, actual cause of tobacco, and then it is nutrition -- excuse me. Poor diet and then physical activity. I think alcohol abuse is the next. So that is well-established, at least within the public health work, and I have to assume there was a research base behind coming up with that. I can't quote it.

So that is the framework that's, at least in the public health world, very well established.

DR. STOTO: It's a pair of articles by McGinnis and Foege that did that. But I'd like to build on what Matt said, that we need rationale for choosing these things, and part of it is embedded in a causal framework that leads to outcomes that are important, and that's part of the evidence there.

But it's also looking upstream. We know that there are interventions that could make a difference, and there's evidence there as well. So it's really part of a causal framework that we know that we can do something about, and that will get us to where we want to be.

DR. STANGE: I wonder if we're serious about the idea of this is a proof of concept, if there's something else besides even embedding those in a causal framework that we should do, and that's to maximize the diversity of the types of approaches.

I still wonder if, this is probably a question for you, Helen, if it would be

worthwhile to think about a different kind of thing that is more of an outcome, that's not about us saying okay, we're really smart. The folks at HHS are really smart, and these are three really good things to do, that good things will happen if you intervene on them.

If it's about saying let's see how it could reframe everything if you chose something that's a functional health type of measure, and said we're going to develop measures of this.

We're going to say here's the concept. Here's some measures that are available, not over-specifying who uses the measures, saying that there will be different levels of groups that will use this. Some could be community measures. Some could be a whole state might decide to use some measures. Some of them might be an employer. Some of them might -- it might be a health plan.

And say we're going to look at the functional health status of our people. We're

going to measure that, and then we're going to get together and take a whole systems approach and say who needs to be at the table to, at our whatever level, whatever community, whatever group, to do something about that?

I just wonder if that would be an interesting contrast to these others, that we might learn something interesting that could inform the next steps.

DR. BURSTIN: I was actually going to say something similar, and that was making a comment, that there's also nothing that says that we can't, as part of this call, ask for both the determinants as well as outcomes. But I think we just need to be tight in what we're asking for, because I think otherwise the universe could stream in, and you'll be working on this committee for the next six years.

So I just think really being focused would be helpful. So actually our staff had done a sort of quick and dirty review of what

we thought were out there, in terms of population health measures. Again, measures like these, there's a measure that CDC has on avoidable mortality, 45 to 64.

I mean, might that be a nice framing, to bring in some of the determinants, and allow some of these more general measures that could be used at a community level in these consortia, to get at the outcomes piece?

I think the functional health status stuff is a little more difficult because it's patient reported. There's a whole other project beginning on that. There's so many other feasibility issues, etcetera. I think some of these -- I just maybe it would intrigue me to have you guys just think about whether you'd want to actually consider a small set of those outcomes as well.

DR. STANGE: Well, it doesn't have to be patient-reported. I mean there are, there are community reports of this kind of measure.

MR. STIEFEL: Nor do I think we

should rule out patient-reported. My favorite quote from John Ware is if you want to know how Mrs. Smith is doing, unfortunately you're going to have to ask her.

That single question of self-perceived health, reliable, valid, predictive, easy to gather, used in all of the national health surveys, including BRFSS. Why not consider something like that? We're talking about measuring health. What about a measure directly of health?

DR. JARRIS: I think the United health rankings do have a couple of questions, one on perceived health and one on mental health, I think.

MR. PESTRONK: They do, and so do the county health rankings.

DR. JARRIS: Yes. Those are derived from United, so --

MR. PESTRONK: We've been talking about two, at least two things simultaneously or sort of in parallel.

One is what to measure, which is the determinants and outcomes conversation, and then sort of woven in that conversation has been how will we determine whether they're good measures or not?

There have been two or three different sets of criteria proposed, for how we would determine whether they were good criteria or not. One are the criteria that NQF has traditionally used, and then there are other -- there's at least one other set of criteria, which are the consensus standard on quality in public health systems.

The aims that are there is the second one, and maybe there are some others that have been mentioned as well, because the work of this Committee is to, from whatever population of measures are proposed to it, to use some structured framework to arrive on what the Committee will ultimately endorse, to be used by whoever chooses to use them.

So both of those things have to be

created, before we're able to get to that last step of being asked whether we want to endorse them or not. Is that sort of what's been going on here?

DR. BURSTIN: I think so. I mean, I think that's part of how we began the discussion about the NQF evaluation criteria. We then talked about how the influence of the public health criteria fit in.

I think our goal would be that at the end of this process, you would have a version of the evaluation criteria we review, because we are NQF, that incorporate in some of those key elements you think are going to be really important to assess public health measures.

So I think it's going to be a blending, which is why we just started the discussion today about the evaluation criteria. But you're obviously right. You can't look at these measures until you have some basis to figure out how you're going to determine if they're a good measure.

DR. STANGE: So I'm not sure a process matches the outcome. I don't quite know how you get from a large group discussion with 20 people, to the how-to. I mean that seems like it's a smaller group activity. How can we help get there?

DR. JARRIS: We are an hour into this two hour conversation, and I was at the same point. I would love to know what people think. Why don't we just conclude, accomplish, move on in the last hour, and if we are going to take the next hour, and we need it, where should we be going in the next hour? Does anybody want to take a crack at that?

MS. MERRILL: So given that this document, the DHHS characteristics of quality in the public health system have been developed by consensus, could we look at these nine and say which of them we think are suitable to be NQF criteria?

Are there some that are better than

others and that would help us, that would be worthy of including? Does that seem reasonable? Because this has been -- work has been done on this thing.

(Off mic comments.)

DR. JARRIS: It's like the five aims, and it's the corollary for public health of the AIMS for clinical medicine, and I think we, over time, want to make sure we hit each of those.

DR. STANGE: So Bobby and Jackie are suggesting, Bobby really and Jackie now suggest a process where some group does, either we take existing work or subgroups do some work and present us with a set of alternatives.

I mean, it's hard for a group this large to do -- we've kind of given the lay of the land, but to really nail it down to something we're going to choose between and weigh the alternatives, there needs to be some intuitive work done, it seems.

MR. COHEN: I'm in favor of subgroups.

DR. STOTO: To what degree are the LA folks going to do that?

DR. BURSTIN: It's not clear how much they're going to engage specifically in the evaluation criteria, but it's something we should follow up with them, to make sure we're not being duplicative. The other question is whether it's the group who actually could help work with LA on some of these issues as well.

DR. JARRIS: Yes. I think we should, I mean, worry about sending LA off by themselves to come back with something. We really need to meet together with them. It's a shame they can't be here today, really to hear what's going on and inform it. But I don't think they're going to be the sage that comes back to us with the answer.

MR. PESTRONK: What was the third area, you know. I described two things that we've been talking about. The other, and

maybe what we're doing is framing out what it is we'd like to receive. That's what we talked about at the very start of the conversation. We don't know what we're talking about, because we don't share a set of definitions, and we don't use language the same way.

So we want to make sure that what we get back, at least has those three parts to it, so that Kurt then when the group is ultimately doing its work, it knows exactly here's what we're talking about, here's how we're going to -- here's the frame through which we'll select measures, and here's the process that we'll use to do that, to do that selection. We don't, and that's not all nailed down yet, it seems to me.

DR. JARRIS: Matt.

MR. STIEFEL: I guess I just lifted my tent up to agree. But it's, I think, a framework or a model, on which we could hang measures, and distinguish between determinants

and outcomes, and show how the measure set that we prioritized or how we prioritize the measure set, it's with that framework. It seems fundamentally important.

Otherwise, it just seems like a laundry list, or random, you know. So it likely leads to measures of things like nutrition and smoking and exercise, but it seems much -- I'm much more comforted in sort of arriving at that conclusion after a framework in which we can point to how these fit in the causal pathway.

DR. STOTO: You know, I think that there's probably something like that in most NQF measures that's implicit, you know, structure, process, outcome kind of thinking. But given that the nature of this population health, I think it helps to be explicit about these kind of things. So I would support that as well.

DR. JARRIS: And so thoughts about the framework in which to hang the measures

on, distinguish between determinants and outcomes and prioritize among them, thoughts about where we would derive such a framework? Is this the small group to go away and do that, or would be easier to do the nine aims?

MR. MASON: I mean, I think part of my issue is I'm a very visual person. I hear a lot of stuff, but I can't see it. I don't see like charts and boards. I think it might be interesting to get those charts back.

I think they were here earlier, and start writing what would be in the framework for population health, and everybody just starts throwing everything up on the wall. Then we can start kind of cutting some things out, piecing them together, linking them. But it's just really hard to look right in the middle when you can't see it.

DR. JARRIS: Yes. It's also a lot easier to react to something, than to create it, especially in a big group like this. So it may be that subgroups are the step that we

need.

So let's think about where we go now in the next hour, which could be on with the agenda, we finish an hour earlier, or is there a way we can use this time now to move forward on this notional framework?

DR. MEDOWS: Well, could I also ask -- I'm sorry, over here.

DR. JARRIS: I just didn't know where the voice was coming from.

DR. MEDOWS: It's the voice of God. Do we want to answer these questions, to help decide about the next step, or do we want to do the next step, in terms of breaking out?

DR. JARRIS: What's the pleasure of the group? Take a look down at these five, I believe, questions?

(Off mic comments.)

DR. JARRIS: We're deciding where to, and this is an open process, okay. I just got appointed to, like a few hours ago, to chair this thing. So you're all more qualified than

me. So let's talk about where we want to go on this.

I mean we, you know, if it's the framework we're looking at, I mean, we pretty much either can adopt an existing one if we want, or think about what attributes would a framework have.

(Off mic comment.)

MR. COHEN: I wonder whether if we have maybe three different groups and three different measures, and gave the groups the ability to focus specifically on the measure, say nutrition for example, or food or whatever we want to call it, or the ability to kind of raise some of the meta-questions, and we each took a half hour in our groups to kind of --

Because it feels like if we had some dialogue, we could come up with some real constructive ideas, and then we could mesh it. It feels like we're a little stalled here, because on one hand we're dealing with very big ideas, and on the other hand we're dealing

with a lot of specificity.

DR. JARRIS: Sue.

DR. PICKENS: Well, I'm kind of struggling with, I guess like you, where to go next. The American Health Care rankings and the county health rankings have a really nice framework that you can look at, put on the wall, and I'm not saying we have to use that one.

But that's one to start with, where you could put the measure framework, each of the measures in there, and you'd know where they sit and what the causal pathway would look like. I have it on my little iPhone.

DR. SPANGLER: And I would say maybe the county health rankings have a similar type thing, yes, both. But I would also, I thought you were going to mention this before, but another -- it is community; it's also personal. But another index, and it goes along with not just health but also well-being, is Healthways and Gallup's Well-Being

Index, which really gets down, and we've talked about this at NPP, but I mean really gets down to individual level, but also can be brought up to the community level.

It's also the one thing that has -- one of the huge benefits, it's real time. I mean, this happens daily, every single night, and a lot of changes can be done with that as well.

So I mean that's another -- those are really the three, I think, that we have now, the state health rankings, the county health rankings and the well-being index, that actually look at community health and well-being.

I'm not sure, besides the BRFSS and the other data and stuff like that. But all those derive from BRFSS, but the bigger frameworks.

DR. STANGE: Some of the questions -- if we were going to spend the next half hour in small groups, people can talk and chew on

things. Some of the questions we have on the table are the what, and we've chewed on that a fair amount, about the three health behaviors.

The how, which involves perhaps developing a framework that's more theoretical, and then the how also about the measures. Then there's implied here of who. If we were -- let's take a few minutes. If we were going to do a small group, what would the small groups be about? What would the charge be?

(Off mic comments.)

DR. JARRIS: Postprandial narcosis.

DR. MEDOWS: What if each of the -- what if we broke into three separate groups, used either the county or the state health rankings as the framework, and then just used it as something to bounce ideas off of, to try to work it through for each of the individual areas?

Then the three groups come back

together to report out on what they were able to find that they thought needed to be changed, what needed to be added, what would work well, and what additional ideas they generated? We should, perhaps, I guess go eat some more cake and be quiet for a few more minutes.

DR. JARRIS: No. I'm beginning thinking about what is the outcome we're trying to reach here, and yes, we really do need to know from NQF what is it you're looking for here. Because the community, United Health rankings and the county health rankings are based on United Health rankings.

So that's a fairly complex framework that's weighted and has attributes under it that may change from year to year, hopefully not. So I'm not sure -- to me, that's not striking as exactly what we're looking for here.

DR. MEDOWS: I think I don't mean for us to mirror them. I'm just trying to get

them to use them as something to get the conversation going to the next step. We seem to be stopped.

MR. COHEN: I mean, I think what we're looking for is a shared vision of the criteria to use with rankings, and by actually doing the rankings, it may make it more concrete, which is why I agree with that recommendation.

I don't think we'll exactly do that. I think what's important is to have open conversations, where we kind of work at this, and then kind of come back and hopefully the clarity of different groups will support and mirror one another.

If we do that for a half hour, we then have some time to kind of have some shared conclusions.

DR. JARRIS: Mike and Bobby.

DR. STOTO: Maybe this is just what you were just saying, but in a different way again. The question could be what do the

county health rankings, can they serve as the framework that we need for this activity? Why or why not? I mean, that would help us think through what attributes we like and don't like.

DR. JARRIS: Good.

DR. BURSTIN: I also think it would be useful to actually have -- I mean, I think it would be useful to have that, a group that wants to think about framework, and whether some of the existing frameworks exists. I think one group could do that, and whether it's applicable to what we're trying to do today.

I still think it would be useful to have a group who would like to help us think through this issue of how you would evaluate these, and how do we kind of reconcile what we've already got on the NQF side, perhaps for public health side.

Then I guess the third thing is, is it also potentially going to have a group

that's going to think about scope, because we keep having this discussion about how broad we want to go. Maybe that's just a simple way to get something quite concrete out of it, that might be useful in a half an hour discussion.

DR. JARRIS: The groups are framework, how do we evaluate, and scope?

MR. STIEFEL: I've become a collector of these frameworks just for fun, and have developed my own sort of synthesis of them. So I think sharing the frameworks, including the county health rankings is, going back to Evans and Stoddart, probably would be useful, and would be a way for this group to take a framework and build and adopt one.

I don't know that we can do that during the next 15 minutes, but I'd be happy to work with a subgroup.

DR. JARRIS: You know perhaps, because again, we're going to need to provide people with something to look at, something to react to, and I don't know that again, that we

can do that in the next 15 minutes either. So maybe we should think about, as a next step, a subgroup maybe telephonically or a webinar, the meeting might be a webinar, and perhaps using these are the three groups you propose; one to look at the different frameworks, and we already have a co-chair for that one, a co-chair for that subgroup. Now the other two groups you mentioned --

DR. BURSTIN: Evaluation and scope.

DR. JARRIS: Evaluation and scope. Are there those who have an interest in those?

DR. BURSTIN: Especially since we need to look forward to having a call for measures and a way to evaluate them. So those seem like the two other very concrete things we'll need to have people engage in.

MS. SAMPSEL: I think just because I do a lot of work on how to choose measures, what measures to use, where we get them, evaluating measures is an area I'd really like to be involved.

DR. JARRIS: Okay. We have Sarah as chairing that one. Who's the next person who wants to speak?

MS. MERRILL: Are you next in line, Ron? Okay. So when I was evaluating the measures, you know, that we had to score, the question that was the most meaningful to me, coming from a public health background, was the feasibility question on the usefulness for public reporting.

That question really puzzled me, because it didn't seem like the meaning of public reporting for that question was can a health plan or anybody else who's using this measure, put up on their website. That's the public reporting idea. I thought that that's what that meant for these measures.

But that's not the public reporting idea that I have in my mind, coming from the public health system. It's what value would these things have for the public to know about. Not how do I evaluate this health

plan, but how am I going to -- you know, what does this mean for me living in society and my health, you know. This idea that how am I doing as a person living in society, as I make my choices.

So many of these measures aren't, they don't really have a lot of meaning for people living in communities. They have more meaning for entities that are providing services.

DR. JARRIS: Which is interesting, because looking around the room, I don't think we have a consumer representative here. Obviously, we're all consumers per se, and it's interesting that most of the NQF clinical measures are designed for clinical entities who are steeped in this kind of work.

If we're going to do population health measures, one of the consumers of this ought to be consumers and the general population, or parks and recreation, transportation, mayors, people like that. Yet

we don't have those people at the table.

MS. MERRILL: It's just I didn't have any way to like, to compute that question. That question really puzzled me and bothered me a lot in this. So anyway, that's another one of those --

DR. JARRIS: So we have our third chair of the evaluation.

DR. BURSTIN: That's Sarah. Sarah's doing Scope.

DR. JARRIS: Oh scope, okay. So Evaluation, you're on that committee, it sounds like. Scope in terms of where is the appropriate entity to be measured or measure themselves by these. We've scared everyone away now.

(Simultaneous speaking.)

MR. BIALEK: I think I belong in the remedial class, because I'm still struggling on question number one. Well, I'm thinking about the measures and their application, and I'm thinking about the issue of one of the

criteria, which is disparity, another feasibility in terms of data.

So if I had a measure around nutrition, and I were Kaiser Permanente, and I have my defined community, I'm likely to have my data and I probably could define disparities within my own community. I might be able to, maybe, and I can address that. The measure would be fine, and I could use it and I could make something of it.

On the other hand, if I were a county and my data sources are quite limited and I have the BRFSS, and I cannot really tease out of that disparities, and I can't really tease out of that more real time data to deal with the particular issue, the measure might not be all that meaningful to me.

So I'm wondering how we deal with this issue, you know, which population or populations are we focusing on? I came into this thinking, the population of a community, defined potentially geographically. Then

there's the community that's defined by a business or defined by a health plan.

I think the measures really the feasibility issue, the disparity issue, the nine HHS aims, whether it's vigilant or whether it's proactive, etcetera, really do vary a great deal by the type of community we're talking about.

Again, so I don't know, I don't know how to deal with that. But that's just something that's been going through my head for the past hour as we've been talking, because measures mean many different things to many different communities.

DR. JARRIS: So this is the scope question. You're not chairing? Michael.

DR. STOTO: So two things. One is I want to be on that committee, the framework. But two, to Jackie's point. I think about this, these measures as tools for managing the population health system, not for thinking about how I behave as a person, to improve my

own health.

I think that it's important that they keep that in mind. I mean, I worked on Healthy People 2000, so that was quite a long time ago. But one of things that kept on coming up was this was a way to communicate to the public about how they should behave with respect to diet and so on.

I don't really think that's true. I really think it's about how we manage the system that we then should be focusing on.

DR. JARRIS: Great.

DR. STANGE: If we were going to have these three committees, Framework, Evaluation and Scope, let's just see who would be on them. Who would be on Framework?

(Show of hands.)

DR. STANGE: Yes. Just from what you've heard. So Framework, Evaluation and Scope. No, but I just wanted to -- I don't want to make a big deal of this. I didn't want to do a 30 second straw vote. So who'd

be on Framework, based on what you know?

(Show of hands.)

DR. STANGE: So we've got about six people. How about Evaluation, Evaluation Measures?

(Show of hands.)

DR. STANGE: Really, only three? Okay, four. Okay. So four or five. Scope?

(Show of hands.)

DR. STANGE: So not a bad split. So it could work.

MR. STIEFEL: You know, it's probably okay, because we'll all come up with interesting things. They are related to each other, fundamentally related to each other. But it's all right. It may just be we, you know, fuel this fire.

DR. JARRIS: But also perhaps subsequent to the meetings, then, the chairs of those might get together with Kurt and I, and talk about them.

MS. MUNTHALI: That's a great idea.

That's a great idea.

MR. STIEFEL: Then there could be another iteration actually to say wait a minute, we can't compare to what they said. We're all off or we're 100 percent correct.

DR. STANGE: So and not to procrastinate that, but we do have, I guess, contractors that will be on the phone at three. We've been working hard and deserve a break before that. What if we started a little bit late tomorrow and had a breakfast, you know, groups -- breakfasting of these groups to get a start tomorrow morning?

DR. BURSTIN: I don't know that you have to be precise about the three o'clock. I think we're probably okay. Elisa, you want to give us some guidance then?

MS. MUNTHALI: You want to start it a little bit earlier today?

DR. BURSTIN: I'm just saying, I think we should just do it if we can.

MS. MUNTHALI: Yes. They'll be here

at three. So they'll be waiting, listening in. So it's fine.

DR. BURSTIN: It's fine. That's what I'm saying, is I think it's fine to take a little bit longer this afternoon on this discussion if it's important, before we get to the measures.

DR. STANGE: Do people have energy for that now, to break out, or would you rather do it over breakfast?

DR. BURSTIN: I think we're also losing some folks tomorrow. So I'd prefer to get some of this foundational work done today.

DR. STANGE: Okay, go ahead.

MR. MASON: So basically what you're saying is get the groups together right now and kind of define what their scope is for their group, right?

DR. STANGE: So to speak, yes.

MR. MASON: It's their charter, whatever.

DR. STANGE: Right.

MR. MASON: Yes. I think that's good idea.

DR. JARRIS: So we can have --

DR. STANGE: Why don't we do that? Your group meets for 25 minutes or so, take a little break after that. If we come back at three and do a brief report back, and start a little bit late, is that doable?

MS. MUNTHALI: Yes.

DR. JARRIS: Okay. So Matt, you were doing the Framework; Sarah was the Evaluation Methods or Evaluation Measures; and Ron was doing the Scope. Okay. Do each of you want to find a spot here?

MS. MUNTHALI: I was going to say, you guys are all right there. Why doesn't somebody come over to this side.

DR. JARRIS: We have the areas back here, and back here, yes.

DR. BURSTIN: About 30 minutes is fine.

DR. JARRIS: Right. Let us know

where you're going and let us know --

DR. STANGE: So Framework's already clustered over there. How about Evaluation here and then Scope over here? So Scope to your right, Evaluation to your left over here, and Framework over there.

(Whereupon, the above-entitled matter went off the record at 2:23 p.m., and resumed at 3:08 p.m.)

DR. STANGE: So let's go ahead and do two minute report backs from each group for three minutes each. Any volunteers? Rhonda, you ready for the Scope group? Whoa, visuals. For the folks on the phone, we're reporting back from some small groups. We have three small groups to do brief report backs, and you're missing phenomenal visuals here.

MR. BIALEK: For the Scope group, we looked at three different -- I'm going to start singing in a moment, and you're really going to be in trouble. For the Scope group, we looked at scope in terms of the actors and

stakeholders. Secondly, the population that the measures would apply to, and thirdly, the scope in terms of the scope of the measures themselves, what they should address.

So for the actors and stakeholders, oh by the way, members of the group, just raise your hands so folks know that I was not responsible for this, but you all were. Okay. So the actors and stakeholders. You know, we determined it's healthcare providers, insurers, payers, businesses, governments, community-based organizations, et cetera, et cetera, et cetera.

It really applies to organizations, individuals even, who wish to use and apply the measures. Which then gets to well, what is the defining, what's the population we're looking at, and the group decided we really should be looking at geographically defined populations, not populations defined by individual organizations.

There was some discussion around

that, and part of the rationale for that was that whether an individual is part of the health plan, whether an individual is in a business, the entire community, the environment of the community, the policies that affect the community, et cetera, affect the health of the individuals within the business, within the health plan, et cetera.

So the group came to consensus pretty quickly, that the community that the measures apply to should be geographically defined, not defined by organizations. Last but not least, scope of the measures. Clinical measures, behavioral measures and community measures.

Community, broadly defined, is environmental, socioeconomics, intervention/community services and policies fall into that as well, and even community assets all fall into the community scope here. Then -- pardon? Oh.

Then the group -- and the group ended up posing a question, which the question was

more of a statement than a question. The question was given scope, given geographic population distinctions, maybe NQF should focus on community preventive measures, that that really should be the focus, because so much work has been done on the clinical side. This is the time to make a case for, and make a real mark and a real statement on community measures.

What does community measures mean? Community measures could be things that affect the environment, policy, others. Not clinical services. The Guide to Community Preventive Services, yes, yes. Yes, the Guide to Community Preventive Services would have some of those measures in it. The group member wish to add, wish to say I missed the boat?

(Simultaneous speaking.)

DR. STANGE: Sarah, do you want to talk about how do you evaluate?

MR. STIEFEL: Can we ask questions?

DR. JARRIS: Why don't we take one

question?

MR. STIEFEL: I have a three-part question.

(Laughter.)

MR. STIEFEL: Okay. I have to pick one. In the Scope discussion, did you talk about the denominator, what the population is and specifically if the population could be something other than a geographically-defined population? Whoever was in the group.

MR. BIALEK: We didn't discuss that explicitly. However, if one were to define the population geographically, then the denominator would be the, I would think the population within that geographic area, whether it's a block, whether it's a state, whether it's the nation, etcetera. But we did not discuss that specifically within the group.

MR. MASON: I think they said it would be cutting it too fine. Matt, over here. It would be cutting it too fine if you

said a subgroup within a geographic group. I mean you get two down to a level that you couldn't measure.

DR. JARRIS: Although if you were looking at disparities within a population, you might have to do it more defined, to identify --

MR. MASON: But you start it in geographic, and then you could do subgroup analysis after that.

DR. JARRIS: Yes. Okay next, Sarah.

MS. SAMPSEL: You really don't have three parts to your question?

DR. JARRIS: Submit them in triplicate.

MS. SAMPSEL: You know, we just didn't do the written report, but basically what our group was talking about would be starting the conversation about the evaluation criteria, and how they might look different for population health or community health measures.

And, you know, what we agreed to do is start with the criteria, you know, that Helen started discussing this morning, and seeing how we may have to adapt those, when evaluating population health measures.

Because for some of you who have performance measure background, in looking at the measures that we reviewed for today and tomorrow, some things just don't fit as well. So we have to find this point of fit and unfit and how to define those types of things.

One way that we're going to do that is by looking at the consensus statement on quality in the public health system, although in our quick review, that obviously has a lot of overlap with what we're already looking at, as well as crossing the quality chasm. So trying to bring those all together, to really define what we're going to look at.

We talked a little bit about we're going to have to change, I don't want to say "change the language," but maybe address the

language disparities between the typical performance measurement, translation of things to the public health type domain, and on the way down to consumers, and how do we make this all transparent, to make it actionable.

What we had started to do at the very end was using, you know, one of the examples of a public health measure. So from the National Vital Statistics report, the percentage of premature death, and thinking about when you're looking at something that historically may have been a surveillance measure, and we want to convert it, or there's an interest in converting it into being something that tells us a story that we can translate, that we can do something about improvement, how does that translate into criteria to evaluate?

We had just started that discussion. So we'll have much more to report later.

DR. JARRIS: Thank you. Matt. You can embed your questions in your presentation.

Can you use the mic, Matt?

MR. STIEFEL: I mentioned that I collected these models and, you know, a lot of them you can trace historical roots to Evans and Stoddart. I came up with this just because there was something missing in all of them, and so this is just a framework that, you know, might be useful.

So it moves basically from upstream to downstream, starting with these upstream determinants of genetic endowment, socioeconomic factors, physical environment, and then the first potential contribution of health care and prevention and health promotion upstream.

You know, when we were discussing it in our group, I think it was Larry that first said you know, it's kind of cheating to have this box called socioeconomic factors, because it's like everything else goes in this box, and the group was talking about maybe having government programs and policies called out,

and maybe affecting the entire continuum.

But those are the upstream factors leading to individual risk factors shown here, behavioral risk factors which lead to physiologic risk factors that can be measured in a health system, like blood pressure and glucose and BMI and things like that, and also leading to resilience and also affected by resilience. All of these factors influenced by the upstream determinants.

These individual risk factors influence further downstream disease and injury, and that's mitigated, for better or worse, by medical care, the second potential contribution of the health care delivery system.

So far, we're not talking about population health in this entire framework, and then downstream from there are the measures of population health. States of health described here as death or self-perceived health and functional status, and

even further downstream from there, well-being or quality of life.

I think important to distinguish and important to distinguish the measures of health from the intermediate outcomes, two people with the same disease state or injury status may have very different levels of functioning or self-perceived health, and two people with the same functional status might have quite different self-perceived quality of life.

There are feedback loops all throughout this framework that are important to take into account, that it's not a linear model, that for example, well-being obviously has influence on socioeconomic status, and then over to the right, it's just for sort of graphical purposes, to show the distinction here between individual and population health, is that all of these factors, this bar says disparities, for all of these factors you can measure the distribution of health, or

distribution of these factors.

It's not just the goodness but the distribution, as we talked about earlier. So that's a framework, and you know, it's one of many, I'll admit, but a framework on which you could hang the measurement activity that we're talking about. So in the agenda so far, we've picked two boxes, this prevention and health promotion box, and the behavioral risk factors box.

But you can see in the broader framework there are only two of the broader set of determinants and outcomes in health, and it might be useful, even if we land on things like nutrition and physical activity, to show that sits here, that influences this sort of causal pathway of influencing physiology and resilience, downstream determinants, disease and functional status, and then the things, probably even more importantly, the things that affect those behavioral risk factors.

In our discussion, we talked about if you pick a measure like what we talked about in terms of nutrition or smoking, you could go through the discipline of seeing how that, in each of these domains, how measures in each of these domains have an influence and relate to the measure of smoking or physical activity.

There's one last thing I'd add, is that this is still obviously a highly simplified model, and really still in the level of a logic model. There was some discussion earlier about the work of Bobby Milstein and Gary Gersh and Jack Homer to develop a real functioning model, a simulation model of population health, that we're now experimenting with in a couple of the Triple Aim communities.

So that actually measures what influences smoking status, and what impact smoking status ultimately has on downstream outcomes over a period of 20 years in the community. So that's a much more

sophisticated model. I think it's harder to use as a framework than this more simplified logic model.

I just wanted to point out that those more sophisticated models are out there as well.

DR. JARRIS: Larry, did you have a comment, and then we probably should move on?

MR. COHEN: Sure. Thanks, sorry. I just thought this was very, very constructive. One of the questions that came up about it, and also about the Los Angeles report, was about the purpose of the documents, because there's a different, and I think this works very well for our purposes.

One of the questions we had is the, you know, the credibility factor, and you know, so it probably depends. Is this to inform our thinking, in which case I think it works very, very well. Is it to disseminate more broadly to explain our thinking, and our bias was that we need to explain our thinking,

and also that all the work that LA is doing, that a lot of that is valuable thinking and resource for the field.

I think someone commented earlier it's just internal. But I would certainly think that a lot of it should be disseminated, you know, or at least, you know, as part of a statement that's broader than that. I think that's important to understand from the onset.

In terms of the dissemination, I think one of the problems with this framework is that on the left hand side, there's a small line, and that line is supposed to represent inequities and all the work that's done on inequities.

There are a number of groups, Prevention Institute being one of them, Policy Link another, and a couple of others, who really looked at the underlying community issues to focus on inequities. I would think we would want kind of a, some kind of diagram that talked about the inequity strategy, maybe

as an accompanying piece, if it's going to go beyond this room, because I think it's very, very important that we say dealing with inequities is incredibly important at the same time that we're dealing with overarching quality.

I really think the arrow, you know, is intended to do that. But from a visual perspective, I could see it as very diminishing to people who are not just thinking conceptually. There is work, and as I said, interesting. At one point Policy Link and Prevention Institute were funded separately and didn't know about it, to delineate the community factors related to equity, and came up with almost the exact same list of factors.

So it was almost like the scientific experiment. We did completely separate research, but came up with the same answers. I think it would be easy to turn those into a chart, or something to kind of lay out kind of

the community, the community efforts that require measures, to have impact.

DR. JARRIS: Thank you. Thanks everyone, for your flexibility in putting that together. I think that will inform our work as we go forward. Shall we move on at this point to next steps?

Yes. Let's keep in mind. We're going to go through this next section here as a way of -- well, first of all, immunizations are a nice bridge between individual and population care, but also as a way for us to learn the NQF methodology so we may apply it more broadly. Keith.

MR. MASON: Maybe we don't answer it right now, but what's the now what of forming those three groups and then putting this out in the larger group? What do we do now?

DR. JARRIS: Well, let me ask the folks on the group. Would it make sense for you to get together for an hour on a call, and finalize this a little bit more, so that you

can then present it back to the larger group? So that we can have that scheduled between the chairs and the committees. Did anybody capture who was on what group, or maybe we could just send a sign-on list around.

MR. COHEN: I still think there's a bit of a question, based on what Keith was saying, of and then when we do that. It's kind of how do we get traction from it? Where does it fit with other work?

DR. BURSTIN: Right. I think some of that will be our next steps, about developing the call for measures. I think we'll also want to feed all this information back to the folks in LA, to make sure that all -- we don't want them going off in a very different direction. So we'll be sure to share all this with them.

One question might be whether one of these groups or multiples want to actually have a conversation with them as well. I think the Framework Group, in particular,

might be very useful.

Measure Consideration

DR. WINKLER: Okay. All right. We're going to move you into sort of NQF's traditional work, and by looking at measures of influenza immunization. Now because we know the slides were difficult to read earlier, we've also given you a printed version. So Sheila should have handed this out to you.

So for those of you, we really do want you to be able to read this. So you'll have, you have both the screen, which I think is a little closer and a little easier to read, but also you have a written version and you can make notes.

Also what should have appeared at your seat is one of these little gizmos, okay. These are actually going to be little voting tools, and we'll show you how to use them when we get to that point. But it's a way of capturing a group vote on things.

So as we go through this, there will be opportunities to vote on things. So take note, that that's what this is for. Please don't take it with you, just leave it at your seat when we're done today.

All right. So what we'd like to do is talk about the first six measures of the 19 that are part of this project, and they all speak to influenza immunization. If you notice, there are even two more on there, which at the bottom are two additional measures that are in the NQF portfolio, that were recently evaluated, that are influenza immunization measures as applied to the nursing home population, both short stay and long stay.

I think the first thing that becomes very obvious is we're measuring one thing with eight different measures. Last week, we created the work groups to look at these measures more in depth, in preparation for this meeting. The work group members for this

group were Jason and Mike, Amir, Jacqueline and Linda.

We talked a lot about, you know, what's the deal with so many measures. So we're going to be looking at these, but I think in the back of your mind, those are the kind of questions we want to ask. So you'll see that there are measures for influenza vaccination for health care personnel, for immunization and hospital patients, for home health patients, for outpatients, for the ESRD population, and then in populations over age 50.

So there are different approaches, and it wasn't always quite, you know, this crazy. This actually is better than it was. But I'd like to pull out a table for one of NQF's more recent task force reports on harmonization, about related and competing measures.

I think we just looked at a group of measures that are certainly related, and if

you look at the first column in the second row, which is about measures with the same focus but with different target populations, these are related measures. Sort of the directive or general sense or goal of NQF would be to combine into one measure with an expanded target population, or justify why different harmonized measures are needed.

There is definitely a conversation and a need for trying to reduce this multiplicity of measures. NQF has worked in this space before. Three years ago, we had a project funded by CMS to look at immunization measures for influenza and pneumococcal disease.

At the beginning of that project, there were 16 measures for influenza immunization, and that was just kind of craziness. Some of the measures were assessment measures; some were how many patients were offered, and some were about how many actually were vaccinated.

But the fact that there were all these variety of measures was just kind of crazy. Certainly the need for harmonization, by which we mean that the way it's measured, the specifications are all aligned, regardless of how you might use it in different settings or different populations, but that the measures could work together because they are aligned.

Well, with 16 measures on the table, the committee was really forced to ask the question align to what? So they looked at essentially the current guidelines and the evidence, and created sort of a basic what should a good measure look like, and those are what's known as standard specifications. They created standard specifications for influenza immunization, health care personnel influenza immunization, as well as pneumococcal immunization.

Essentially, the characteristics of those standard specifications were based on

current ACIP guidelines and the evidence. They were focused on being comprehensive measures, to include all recommended populations to the extent that they're measurable. So in other words, big denominators.

Then they chose to specify numerator categories, and we're going to talk a little bit about why in just a minute. But within the numerator, rather than aggregating all of these types of patients, they recommend that these are separated and computed and reported separately.

Those that actually receive the vaccine, those that decline the vaccine and those with contraindications, and then the standardized time window of October through March. It was amazing the number of flu vaccination measures that had totally different time frames, you know, September, July, February. Everybody was in there, and that was kind of very, very difficult to sort

out.

The numerator categories resulted from really a thinking about comparing different approaches to typical measurement. Examples within those 16 measures had all of these. This is a comparison of two sample providers with 100 patients. The first row talks about what happens if you include in your numerator all patients that were vaccinated, those that declined a vaccination, or had a contraindication to the vaccination, all combined together without separating them.

In other words, did the provider do the right thing? So one of those three things is a yes, they did the right thing. As you can see, these two hypothetical providers had identical scores. But let's see what happens to those identical scores when we look at things slightly differently.

When you look at the second row, it's the first row measure broken out into numerator categories, where you specifically

break out those that actually received the vaccine, those that declined, and those that had contraindications, and report these individually.

As you can see, suddenly your two providers that look the same with the first row, don't really look the same in the second row. Clearly, one of the most important goals and targets of measurement is to increase the number of patients who get the vaccine.

You can see that despite equal performance in one measure, many more patients got the vaccine with Provider 2 than Provider 1, even though if you were measuring the aggregated performance, they looked the same. This was an important characteristic that this previous committee felt was an important aspect and attribute of the measure, to provide this detailed information. Michael, did you have a question?

DR. STOTO: A comment actually. I like this example. I'm going to use it in my

teaching on Thursday.

DR. WINKLER: Okay.

DR. STOTO: But the other assumption here is that decline is a good outcome, and that may not be so.

DR. WINKLER: Right. Well, I think that was a large part of the discussion. Clearly this idea of specifying with numerator categories was really the focus of much of their discussion, because it was felt that the declined is something that's potentially actionable.

But if you bury it in the aggregated score, like in Row 1, you really won't know that or won't be able to identify the actionability.

DR. STOTO: Right, and you know, as we get more into population, which obviously we're doing here, that becomes more important than you know, things like if they hadn't been to the doctor, you may want to exclude them. But we may want to think about them very

different in a population setting.

DR. PICKENS: Can I intervene with that declined and give a personal example, because I work at a health care institution, and walked down the hall to our health group in the hospital, and they gave me my flu shot in our auditorium. Then I had a cold and went to the doctor, and he said do you want your flu shot, and I said I already had it. So I'm in the declined category.

DR. WINKLER: No, no. No, you're not.

DR. PICKENS: Yes, I am.

DR. WINKLER: No, not in the way the measures are constructed. Well, that's why we're going to go into more detail. So but if you look at Row 3, which is a very common way for constructing measures, is to take your exclusions for things like decline and contraindications, and remove them from the denominator, and you can see what happens to the measure calculation.

Not only does your denominator shrink and you don't have a way of really monitoring how many people actually were assessed, offered or attended to for flu vaccine, it really does affect the measure results. So you can see that having different approaches to measure construct gives you very different results.

So standardizing the approach was an important milestone, if you will, towards aligning all of these different measures, if they're going to be coming from different settings or different data sources, to at least the construct is the same, so that ultimately, maybe if we move to common data sources, it should be a nice transition, because the constructs are the same.

So it was because of this that the steering committee landed on standardized specifications for influenza immunization, and essentially the numerator is the patients who fit into those three categories and report

them separately, during October through March. They had to pick the time frame, because again, they were not at all standard in the measures brought to us.

The denominator were the number of patients in, you know, whatever you're measuring, whether it's a facility, an agency, a practice or a defined population such as a health plan, during that time frame, and at the time, this was prior to the 2010 change in the recommendations for flu vaccine. But I've updated it so it's greater than age six months.

So this is what the steering committee three years ago felt was a good representation of the type of measure, and they evaluated the existing measures against that.

Very few measures actually met this standardization, and some of the measure developers at the time adjusted their measures, and some of them did not but were

told at their next maintenance review, which is now, that they would need to do so, to maintain their endorsement.

So there is a standard spec for influenza immunization, and is there one for health care personnel.

DR. JARRIS: Have you looked at the October one, because I think it probably ought to August one at this point.

DR. WINKLER: That's something, I think, that can be discussed. At the time that it was created, a lot of the discussion was around availability of the vaccine.

DR. JARRIS: It's now available, at least in the community, in actually July in some cases, but certainly by August.

DR. WINKLER: Yes. Karen was actually the staff who struggled through this, and she can probably speak to that part better than I can.

DR. PACE: I just want to mention that the way that they looked at it is that

they would select the denominator population from October through March, but there would be a look-back. So that if the person actually received it in August, they would be considered as having received the vaccine.

So I mean that certainly could have some adjustments, but I just wanted to assure you that they did count people who had received the vaccine earlier and, you know, they recognized that, you know, it's becoming available earlier and earlier.

DR. WINKLER: Does that answer your question?

DR. JARRIS: Yes, the unintended consequences, it may not drive providers to start offering the vaccine or offering a referral to a place who has a vaccine as early as August.

DR. WINKLER: Okay, noted. Michael.

DR. STOTO: I've got a question about the other end. I mean this can't -- two things. One is this can't be calculated until

April, right? Is that an issue, of the next year, because --

DR. WINKLER: Right. I think that you're right, you do wait until the time frame is over. But at the same time, the fact that not calculating it, you know, after a time frame has gone on is very typical of measures in general. It's usually encounters during the year or something.

So there usually is some kind of lag period that's just very, very typical of measures. It's rare that you have a measure that can be done in real time.

DR. STOTO: Yes. Well I mean, some measures you can measure, it can be done on January 2nd. But this one, this one can't be done by April 1st. That may not be a big issue. But the other thing is that this gives as much credit to someone who gets his shot on February 28th, as someone who gets it on October 1st, which obviously there's not as much protection from the flu. I guess there's

nothing you can do about that.

DR. JARRIS: Was there any discussion around populations who are traditionally under-served with regard to influenza vaccine, whether those are African-American, Native American, lower socioeconomic status?

DR. PACE: There was discussion around that, but in terms of changing the measure, you mean, or stratifying --

DR. JARRIS: A way to capture that health equity issue.

DR. PACE: It's not reflected here, and that's a good question. It's something we struggled with with all measures, of how best to display that. Certainly, the way we've looked at it to date is to try to report measures, based on those particular population characteristics. But, you know, frankly that's not happening consistently. A lot of times, those kinds of data are not available in the same place as the clinical data. So you know, certainly we're always looking for

suggestions and recommendations regarding that.

Measure 431

DR. WINKLER: So with that background, our task today is to look at these six measures, and this work group has looked at these, and we actually have some preliminary ratings from them that we'll share with you as we go through this.

So on our agenda, the first measure we're going to look at is Measure 431. It's the Influenza Vaccination Coverage Among Health Care Personnel. And as I said, there is the standard specifications for that, that is projected right now. But this measure looks at the percentage of the health care personnel who received the influenza vaccination.

I just want to take the opportunity to briefly talk about the evaluation criteria very, very quickly.

DR. STANGE: So just, as we're doing

this, as Reva said, this is the kind of the normal work of NQA, and I'm new to this process. A number of you have been through this before. I think when we were setting this up, we talked about thinking about this as a way that we can learn about the process to which the population measures that we've been talking about, the other population measures that might be new, might be subjected.

Bobby asked us to, as we're going through these, to think about how does this translate to the community. So we can even think about the extensions, which is part of our charge. How might these be extended from individual measures to population measures? Reva's going to go through some things now that will help us to not spend a lot of time having a nice discussion about things that isn't really going to change anything too.

She's going to give us the criteria that all of these measures are evaluated on.

So we can really learn the larger process from that. Then we'll go through and try to apply this to each one. I think you're going to share the votes that were done before, and what we might be able to do is focus our discussion on things that might need to change.

I mean if the vaccine is available earlier, well that's something that ought to be considered, does this need to change. But these are all pretty well -- today and tomorrow, pretty well established measures, and a lot of detailed work has been done.

So I think we can maybe focus our efforts and maybe even save some time, one, so we don't have to do all the phone calls to get through the rest of them. But two, maybe if it will save some time, to continue our other discussions, but then informed by having really gone through some of the existing measures. Is that all fair?

DR. WINKLER: It's all fair. So

okay. So as I was saying, our Measure 431, the Influenza Vaccination Coverage Among Health Care Personnel, is a measure that's brought to us from the CDC, and we do have a representative from CDC on the line. I've just asked if they would like to just make any comments about the measure before we get started.

MS. LINDLEY: Sure. This is Megan Lindley from --

DR. WINKLER: We can hardly hear you, so you're going to have to really speak up.

MS. LINDLEY: Okay, I will speak up. Is this any better?

DR. JARRIS: Yes, that's better.

MS. LINDLEY: Okay, great. So I will just give some very brief comments about, as I think was referenced, this is a measure that had received previously a time-limited endorsement from NQF. So what I was going to do is speak extremely briefly about the pilot project that we did to test the measure, and

just give you an overview of the findings that caused us to make some changes in the measure, so that it's what is under consideration today.

So we conducted this pilot during the past influenza season. We recruited over 300 health care institutions to participate, and we had 234 of them that completed all of the surveys that we requested of them. There were 78 acute care hospitals, 59 long-term care facilities, 16 ambulatory surgery centers, 43 dialysis clinics and 38 physician practices. So we had a variety of inpatient and outpatient facilities.

I'll go over this briefly, because I know it's in the application that you all received. In general, we found that our inter-rater reliability in looking at the vaccination status using the measure was acceptable, and the face validity of the measure was acceptable.

The specifications for the measure

are the denominator includes health care personnel working, as was referenced, between October 1st and March 31st of the following year, regardless of their clinical responsibilities or patient contact, and the denominator is calculated in three mutually exclusive groups, the first being employees, the second being licensed independent practitioners who are physicians, advanced practice nurses and physician assistants who are affiliated with the facility, but are not employed directly by the facility. Then the final separate group is students, trainees and volunteers.

The numerator specifications, I think I don't need to go over, because they were just discussed. It's those that meet the NQF consensus standards for measurement. So vaccination, whether it's received at the facility or outside the facility, declination of vaccination for non-medical reasons, or a medical contraindication.

One change that we did make there was to add a category for unknown vaccination status. So the findings of our pilots were that facilities sometimes had difficulty tracking this in certain non-employee groups, and we felt that adding an unknown category would give them actionable data, you know. It would indicate a need for improvement in their tracking, and it would be more valid than calculating the unknown, based on a simple difference between the reported numerator and the reported denominator.

The major differences in the denominator statement between the measure that NQF had given a time-limited endorsement to and this measure that's under consideration now, is that the non-employee groups are more curtailed. Although we generally had good agreement in the measure, we did have facilities, both inpatient and outpatient, report difficulty in tracking the credentialed non-employees and their other non-employees,

which initially included every single health care personnel, health care worker in the hospital who was not an employee.

So based on that, we felt that it would produce a more valid measure to restrict those groups to, as I mentioned, the licensed independent practitioners and the students and volunteers, because those seemed to be easier for the facilities to track.

I think the only other major change that was made from the measure that had gotten time-limited endorsements was the time frame. Initially, it was the health care personnel who were in the hospital, excuse me, in the facility for at least one day during the influenza season, and now it's working for at least 30 days in the influenza season.

That primarily is a concession to feasibility. We heard from our pilot facilities that it really wasn't possible for them to track again, many of the non-employees who were in for only one day. So the concern

was that the data produced by the measure would not be valid if it were restricted to one day. I believe that is everything in the way of background.

DR. JARRIS: Could I ask a question? So in other words, it's employees and contracted, or health professionals and others who are in for 30 days or more during influenza. If a hospital outsources their food service or custodian services, does that mean that the food service workers and the custodians don't have to -- custodial services do not have to have influenza vaccine?

MS. LINDLEY: Well, it doesn't mean that. It does mean that they would not be included in this measure, and we did have a lot of debate about that. The feeling was based both on sort of the people that were on our project steering committee, and on the data that we got from our pilot, that it would be better to have a measure that was less inclusive but more valid, than to have a

measure that was more inclusive, but included data on employees that are difficult to track, and therefore might not be producing data that is a true representation of how that facility is doing in their vaccination program. But yes, your interpretation is correct.

DR. STOTO: So I'm curious about that Category D in the numerator. I understand the issue there, but it strikes me, if I read it correctly, that you're counting those unknown status as if they had been vaccinated.

MS. LINDLEY: I'm sorry. Thank you very much for asking that. I should have stated specifically each of those categories is calculated separately. So this would allow an institution to use Category A and produce a vaccination rate. Then they could use Categories B, C and D to produce declination rates, contraindication rates and rates of unknown assessment, and that's why it's actionable data. But thank you. Those would not be calculated as vaccinated people.

DR. WINKLER: All right, thank you. I believe of our work group members, Linda, I think you were the person assigned for this one. I just want to briefly review the evaluation of measures. The first criteria, I think, if everybody recalls, is the important to measure and report criteria. It has three parts, the high impact.

I can honestly say that in years of doing measure evaluation, I've seen very few where high impact doesn't pass with much thought. So I would ask that we won't separately vote on that. But if you feel that we're talking about something that doesn't have a high impact, please call it out.

So that the next one is the gap in performance and the third one is evidence. Gap in performance can be defined in several different ways, variability of overall performance. But here's where disparities is really critical, and we really do ask for it, to look on data on disparities, if it's all

available, because there are times when that's where the opportunity is, less so maybe in the overall performance.

You do want to consider the data that's presented, in terms of distribution and representativeness. The third thing is looking at evidence. Key points is we're looking at the entire body of evidence, and it would be nice if that measurement or if that evidence had been graded by one of the traditional grading systems, like with the U.S. Preventative Services Task Force or grade.

Expert opinion is not evidence, all right. It's opinion. So there's still room for expertise and judgment, that we do want to try and be as quantitative about the evidence as possible. We are looking for an assessment of the quantity, quality and consistency of that body of evidence, rather than just calling out one article or one study to base a measure on.

So the work group did preliminary evaluations, and these are how they rated it, and Linda, do you want to take the discussion from here?

DR. KINSINGER: Sure. So as you see, it looks like three of us rated it, and we all said it was high impact. We all agreed that there was a performance gap, in terms of numbers of the percents of health care employees who, health care personnel who have been, received influenza vaccination.

In terms of the disparities, there was actually no information about disparities. So that was a missing piece of information. I don't know whether it's been looked at or not, but it's not reported in terms of disparities among health care personnel, and you see the rationale there, 63 percent coverage in the past year. Should I go on?

DR. WINKLER: Sure.

DR. KINSINGER: In terms of evidence, quantity, which was five or more studies was

all rated as high, although there were four cluster randomized studies, I'm not sure how that got high, because I thought high had to be five or more studies, yeah. I don't know what I did there.

Quality, looks like one rating of high and two of moderate. In fact, the information submitted by CDC itself rated the evidence as moderate, because of some limitations and the fact that the studies that are cited are done in long-term care facilities, as opposed to acute care settings, and so there's some gaps in the evidence in terms of effectiveness of immunization of health care providers in acute care settings.

But the studies that have been done are all internally consistent, and so that consistency was rated as high.

DR. WINKLER: Any comments on the ratings that the work group presented?

MR. BIALEK: Just a question. So where do -- where does the issue of the data,

quality of the data, come into play?

DR. WINKLER: That comes under Scientific Acceptability.

MR. BIALEK: Okay, and the data are self-report or facility verified?

DR. KINSINGER: I think, I'm not totally sure. I would guess these are verified, but I don't know that for sure. I'll try to look it up.

DR. WINKLER: Our folks from CDC, can you answer this question about your data source?

MS. LINDLEY: The data source for these four randomized control trials?

DR. WINKLER: No, for your measure that you tested.

MS. LINDLEY: For the measure, there were different data sources. I will look up which table it is for you, but it was dependent on what the facility could provide. So it could be self-report, it could be electronic health or medical records. It

could be an occupational registry or database that the facility compiles. So it's different sources.

DR. WINKLER: Okay.

MS. LINDLEY: Does that answer the question?

DR. JARRIS: How do you take into, and this is a process overall question. How do you take into account that there is no data on disparities provided? Does that affect the ranking in any way, or is it just something to gloss over and say okay?

DR. WINKLER: I think that will depend on how you want to approach it. Certainly, lack of information around disparities could certainly cause your ratings to be lower. We've had steering committees in the past who basically required information around disparities before they would move a measure forward. So it depends on how strongly the committee feels on that criteria.

DR. JARRIS: The disparity wouldn't

necessarily have to be a disparity among the health care workers. It could be a disparity among the population served by those health care workers. It may be that, you know, lower, facilities serving lower socioeconomic individuals have lower rates than those serving the very wealthy. From CDC, can you respond to that? What would it take to provide some kind of information on disparities among influenza -- disparities among people served by health care facilities, with regard to immunization rates?

MS. LINDLEY: Among the patient populations, not the health care personnel?

DR. JARRIS: Yes, because I think we're interested in people being protected when they go into a health care facility.

MS. LINDLEY: Right. I know that my colleague, Dr. Ahmed is on the phone, and he may want to jump in on that as well. I'm not aware, based on my knowledge of the literature, that studies of that manner have

been done. I know there have been studies talking about the quality of care provided to patients and practices that serve mostly lower socioeconomic versus higher socioeconomic patients, in terms of the physician's education and training.

I don't know that studies of that manner have been done among health care facilities, particularly hospitals. Is it necessary that the disparity that's in question, is that specifically looking at socioeconomic disparity?

DR. JARRIS: It could be racial, could be ethnic, could be geographic.

MS. LINDLEY: I guess the question, because the interpretation that we had been thinking of, going through this process, is that the real disparity that you see, although this is among the health care personnel and not their patients, is based on their occupational categories.

We even found in our study data that

employees had a higher or significantly higher vaccination rate versus some of those other non-employee categories, and also as you know, physicians will have a higher vaccination rates than allied health professionals.

DR. JARRIS: If you look at unnatural causes, that film outlines that extremely well at the university hospital. So that is another disparity, if that's an easier one to get at, because it would probably reflect the disparity in the population being served.

MS. LINDLEY: Right. It would certainly reflect disparities and the amount of protection given to patients, based on the type of health care personnel they were interacting with. But I don't know if that is exactly what the committee is looking for.

DR. STANGE: For approving these measures, what's more helpful? I mean if the measure's otherwise sound, is it more helpful to not approve because we don't have data, or is it more helpful to approve it, with some

suggestions like Paul just made. I mean he really outlined some very interesting categories that could be reported on, which is more helpful to the process.

DR. JARRIS: It seems to me this is far too important a measure not to pass. But the question is it's got to come around in two or three years. We may not be here, but can there be a strong recommendation that when it comes back around, that there is clearly good evidence presented about how this is measured and the impact in disparate, whether it's job categories in the hospital, which tracks really well.

Those people live in the same communities. You can draw the line out as other populations subject to disparities, or whether it's in the population served. But is it?

DR. WINKLER: Yes, absolutely. You can certainly make all the recommendations, and I think that as NQF really pushes this

whole issue around disparities, providing very focused recommendations to a developer on what those disparities really should -- which ones should be addressed, I think, is an important role for this committee to play.

DR. KINSINGER: So it seems that it doesn't affect -- the fact that those data aren't available doesn't affect the quality of this measure itself, but it's a recommendation for use of the measure that we would make. I mean the measure is still reliable and valid without, even if we don't know those answers. Is that not right?

DR. JARRIS: Well, if you're looking at it from the point of view of protecting our patients in hospitals or a long-term care facility is probably a much more vulnerable population, because the vaccine may not even work on them. But the question is who do you spend more time with?

I mean, you know, if in fact your doctors and your nurses are vaccinated, but

you see a food service worker three times a day, and your custodian spends 15 minutes or they're not called -- they're environmental service, whatever they're called now, spend 15 minutes in your room, you have actually far more contact with them than you do that doctor, who you're lucky to see 15 minutes a day.

So it may not be a valid measure of how well patients are being protected, if we're not looking at those people who actually spend more time with you, who are handing you your food.

Then the other thing that really bothers me is if you're allowed to outsource that to food service providers or environmental companies, and therefore wipe it out of the equation, then you really have unprotected patients.

DR. WINKLER: Okay. I see what you're saying.

DR. BURSTIN: It's also very useful

to propose it.

MS. LINDLEY: May I just clarify one thing, the issue about the contracting and outsourcing is unfortunately absolutely correct, and it varies a lot by facility, of course, if those food service or environmental professionals are directly paid by the facility. If they're employees, they would be counted in the employee category.

MR. COHEN: Well, I just had a question about the comment Paul was making, because I strongly agree, that there needs to be a stronger equity component in there. I was just wondering, though, if the responses, if the studies haven't been done, whether there's something that has to be addressed now around some kind of study or some kind of modeling?

Let's just say three years from now, that's going to have to be dealt with. But we're recommending to a group it's going to have to be dealt with, and I imagine they'll

get the exact same answer three years from now as now.

So I'm not quite sure what the implementation, or whether there's a set of recommendations. But somehow we need some work to be done, so that we have the resource. Because the inequities, I mean my experience is continually, the answer with inequities and with communities strategies is we don't have that kind of information.

We haven't done that kind of study, and that's exactly the problem, and that's why we end up with using the wrong or weaker information, from a community and equity perspective, is because the studies are never done. I would hope we could do something about that, but I don't know what it is.

DR. STOTO: So I'm all in favor of gathering data on disparities and inequities, and I'm sure that if we did the kind of thing that Paul suggested, we'd find them. But on the other hand, if you look at the measures

here about performance gaps, I mean the licensed providers are less than 50 percent are vaccinated.

It strikes me that that by itself makes it important enough, that even if there were no disparities, we'd want to have this measure.

DR. JARRIS: Rhonda.

DR. MEDOWS: How strong are our recommendations? How strong is the influence of a recommendation from the committee? Is it a good idea kind of a thing, that may or may not actually come to pass, or is it something that we can tie to you are endorsed with the contingency that this be accomplished by X, Y and Z date?

DR. BURSTIN: So keep in mind all measures for NQF are evaluated every three years. So you can make a very clear statement that by the next time the measure is up for review, there is an expectation that data stratified by populations served and/or, I

think, the employees, would be required.

DR. JARRIS: Then as a matter of process, I believe, and I'm sorry for the speaker on the phone. I forgot your name, and I really apologize, Megan, but I think you said that this received either a provisional or a temporary last time around, not a full endorsement, and what we didn't hear as a group is why. So we actually are not able to evaluate what had to change.

DR. BURSTIN: Actually, that's a standard part of our process, which we're not doing as much anymore. Things are assigned a time-limited endorsement because they hadn't yet been fully tested. So the measure is now fully tested. So it is up for full endorsement for the next three years.

DR. STANGE: So is the question whether it's fully tested if it hasn't had these disparity measures? So --

DR. WINKLER: The disparities testing is not a required part of the testing. We're

testing for reliability and validity in the measure properties.

MS. MERRILL: Does the committee's recommendation travel with this, so that the next committee will see the recommendation?

DR. WINKLER: Yes.

DR. STANGE: So Bobby, I think -- whose responsibility is it to assure that those data to allow disparities to be measured the next time around, are collected? Is it the person or the entity that's proposing the measure? So that if in fact those data aren't available the next time around, then the measure doesn't get approved?

MS. MERRILL: If it's not available, they just have to say why it's not available. But I mean if it's not available, they can't collect it.

DR. JARRIS: On the other hand, the CDC is perfectly capable of commissioning these studies. So the CDC can assure that it is available.

MS. LINDLEY: You have better faith in our budget than I do. But I did want to say one thing, that we would be able to provide to the Committee, although not immediately, that we actually do have addresses for our participant facilities. So we could fund the zip codes for you and construct an index of geographic disparity that way, if that would be useful.

We also collected data, for example, on urban, rural or suburban status. So we should be able to do some analyses that way if that would be useful.

DR. STANGE: So we're actually doing two things at once here. We were using this to actually walk us through the process, and we're learning a lot about the process, and we have serious issues raised by this. Do we want to actually go through the process? We learn about the process and then make note of these, and then once finishing the process, come back and say okay, what are we going to

do about this?

DR. JARRIS: You know, I'd say from my point of view, this is such an important measure, I couldn't go to sleep tonight if it didn't get passed. So I think that it may be imperfect, but it's the best we have, and let's start there with a strong recommendation that's approved for next time around.

DR. BURSTIN: And these disparities issues come up for every measure that we're dealing with right now. So this is not unique. This is an issue where we've got actually a disparities committee working on exactly how we should, what should we require as part of NQF's submission. But we hear you. This is an important one for this measure as well.

DR. STANGE: Is the way to address that systemically then, I mean really because you want to collect these data on everything, rather than doing it one measure at a time. So how is that accomplished?

MR. PESTRONK: So then the way that this works is at this point, the measure, if the measure is adopted, then it goes up as sort of a formal, on the list of approved measures from NQF, and things would continue along. Those who use NQF measures as part of their, you've got to have, you've got to do this in order to get that, accrediting bodies or HEDIS or something else.

The way that organizations would be forced to collect the data that would allow disparities to be measured is someone like HEDIS would have to adopt the measure, and then those entities that needed to demonstrate that they met the HEDIS measures, would then have to --

Because HEDIS adopted the NQF measure, would have to collect the data that would allow them to report on disparities? That's the cascade of events that NQF endorsement leads to?

DR. WINKLER: NQF endorsement

provides a group of measures that any number of implementers could potentially grab hold of. We certainly see a lot of it used by the federal government in a variety of programs. Often, it's driven by the setting of care. So we can't totally foresee where and how, but I think some of the comments on this particular measure shows that the interests in it likely being used, perhaps among some of the federal programs over at the Joint Commission, are sort of in the works, if you will.

DR. JARRIS: We would use it at the state level, because we would go in and respond to a dozen deaths in a nursing home, in you know, several times a year, and in those nursing homes we found out they had vaccination rates of their staff of about 30 percent.

So if I hadn't had a standard like this, I would have gone right to the papers and published, for every nursing home in our state, what their rates of staff vaccinations

were.

DR. STANGE: We have Jackie, Ron and Mike. I'm sorry Madeline, sorry.

DR. NAEGLE: Thank you. I just wanted to point out that there, I see two components here. One is a workforce issue; the other's a population issue. I think the recommendation should be that if you're going to be measuring immunization for the workforce, that that should be stratified. Your population should be stratified there, and then the population served should be stratified as well.

I think that's really a recommendation about the science, and I think it's a good recommendation for us to make, even though it's setting the bar a little high. But I think both of those are important. I mean I would argue for the workforce, we really want to know if the nurses aides as well as the registered nurses and the physicians are being vaccinated, and

that there's not discrimination by position and employment.

So I think it's the kind of recommendation that we can make, but as I said, I also think it raises the bar, and it really means that the science has to be better. I think we certainly can't require it. It might be a recommendation.

DR. STOTO: So I don't think there's anything about this measure that can't be used to look at disparities. It's just that they haven't provided any data on that. So, you know, we're not saying that -- so we're just being and saying is this an appropriate measure, and the fact that they haven't provided data on disparities strikes me as not taking away from the quality of this measure.

MS. MERRILL: Well, you get into a terrific can of worms when you try to stratify the workforce by title. It's very hard to do.

DR. BURSTIN: It's actually part of the measure. They've already put forward.

The measure is required to be stratified by employees, licensed independent practitioners, and then any students or trainees. So they've already done that piece. That's already part of this measure.

MS. MERRILL: So that's just categories. This is title.

DR. STOTO: Right, and that's arguably more important than stratifying it by race or anything like that, because that's really actionable. You can say we have to take an intervention with the doctors and the nurses, the licensed practitioners, rather than the employees.

MS. MERRILL: Well, the way they've categorized it, it's not really by title. So they have given categories that the facility has to stipulate. The other category they could do it by is by the EEO category. So that's professional, administrative, you know like that, technicians. I don't know if that would give you the value.

It seems like the way they want to do it is the most pertinent for this measure, people who are licensed, people who are actually employed. You've seen that data on how hard it is to do it by title.

DR. STANGE: So we have the distinction between the reporting on the population versus the employees. Ron's been waiting for a long time, and then Reva, I'd like you to help us tell how we action these type of concerns for the measures.

MR. BIALEK: So not fully understanding the process, I'm going to ask the question anyway. I'm a little bit troubled about the way the data are collected.

Let's get beyond the disparities piece, that some of the data are self-report, some of the data are based on the facility record of whether or not they administered the shot, and so the measure is used by a facility, and the change in the rate could be nothing more than a factor related to a change

in the way the facility collects the data.

If a facility says your continued employment here is contingent upon you being vaccinated, and the facility is asking for self-report, the rate's going to go up. So, you know, I don't know how that's considered in this process.

DR. WINKLER: Yes. If you could hold that thought until we move to the section on Scientific Acceptability, where it's all about the data and reliability, hold on. It's an excellent point to be made. Right now, we're still trying to finish the importance, okay. Who else wants to talk about importance?

DR. JARRIS: Rhonda, your card has been going up and down. It's like a windshield wiper.

DR. WINKLER: Yes, okay. First time through, it's always difficult. So if we take a look at the ratings that were provided by the work group, does everybody feel this generally reflects how the entire group? Does

anyone have any major issues with the way they are? Performance gap, there is one. It's high. On the evidence, the quantity is high, the quality is moderate to high, and the consistency is high. Okay.

Then as we move to the evaluation of how we take that information and plug it into sort of the evaluation algorithm, moderate to high in quantity, moderate to high in quality, moderate to high means that it would pass the evidence criteria. Does anybody have any objections to that?

(No response.)

DR. WINKLER: Okay. We don't need to worry about exceptions. So I guess at this point, you know, we could do a formal voting with our little gizmos, or is there anybody in the room who doesn't think this measurement meets the importance criteria?

(No response.)

DR. WINKLER: Okay.

MS. SAMPSEL: We're all afraid of

Paul.

DR. JARRIS: No, but it did occur to me that if these gizmos don't take a lot of time, it does respect people's privacy, and then I don't have to go after anybody.

DR. WINKLER: Right. Well, that's why I was doing it --

DR. JARRIS: I want to know who to go after.

DR. WINKLER: Okay. So the next section is on Scientific Acceptability of the measure properties, and this is where we're looking at the specifications themselves. We are looking at the reliability and the validity, and we are expecting those to have been tested and data provided.

Again, disparities may come in this. When we're having, you know, internal discussions about what criteria disparities comes under, it seems to come under a lot of them. Just some guidance points. We are looking for empirical testing. We don't

prescribe what type of testing. We really want it to be tested on the measure as specified.

I think that CDC has outlined the testing that they did and the results that they had. So this is a good version of it. So this was the evaluation by the work group, in terms of the scientific acceptability. Linda, did you want to just summarize?

DR. KINSINGER: Sure. So the CDC did report their study data on reliability and validity, usability and feasibility, and it looks like we rated it moderate to high. Reliability, moderate validity, I think getting to some of Ron's issues about where the -- how valid the data are, but I don't know how you get around self-report.

I mean there's not a gold standard, because people do get vaccines, you know, from the drug store to the grocery store to lots of different places, and I don't -- there's just no way around that. But it does mean it's

less valid, I think.

Usability was rated high to moderate, and feasibility, moderate. I believe the feasibility rating, if I remember here, had to do with just the challenges to developing, to figuring out which category employees fit into or people in the facilities, whether they fit into which of those categories, and then collecting the information, I think. At least that's what my thinking was in terms of feasibility, that it's not -- those aren't necessarily data that are routinely collected for other reasons.

They have to be collected specifically for this, so it challenges feasibility just a little bit. But there we are. That's as good as we're going to get, I think.

DR. WINKLER: Is there any comments or discussion about the reliability or validity? Ron, I think at this point, that might be where your comments apply. Did you

want to ask CDC their thoughts on that?

MR. BIALEK: I'm debating. You know, I hear, Linda, what you're saying, and I'm thinking that, you know, for my employees, we have an employee handbook, and we require if an employee is out for a certain number of days, they need to bring in something from a medical provider, saying what's the issue.

If health care workers have a requirement, they could provide some documentation, which will get beyond self-report. But I understand that. I mean there could be costs related to that, there could be legal issues related to that, etcetera. So maybe, you know, CDC, how do you deal with this issue of the validity of what's being reported?

I mean have you looked at the difference between self-report and documentation of vaccination?

MS. LINDLEY: We did, and I think there are two comments, because you bring up

an excellent issue, and one that we really ran into running the pilot, which is there's not a gold standard, and there are all these different kinds of documentation and how do you do this.

One, a general comment would be, you know, that of course, self-report of influenza vaccination has been studied among adults, and it's been found to be a highly sensitive and specific measure. Of course, those are in the general population, not necessarily in health care personnel, that may have a job requirement.

But there are not as significant problems with recall of influenza vaccination for self-report as there are with other vaccines. The other thing we did was to do a comparison between facilities. I took the three most commonly used data sources, and I'm sorry that I don't have the quantitative figures in front of me.

But I can tell you that by far, the

most common data source reported was actually paper health records. So although the data are not available electronically, they are written down somewhere. The second most common source was electronic clinical data, and then we did look at self-report status, although that was far as less commonly used, which I find somewhat reassuring personally, for the reasons that you bring up. So we had maybe, depending on the categories, say 10, 12, 15 percent say yes, we use self-report. But most of them did use documentation.

When we compared the median vaccination rate among those institutions reporting different types of data sources, we found that although the median did tend to move around a little, the rates were comparable, in terms of being, you know, within the same quartile.

So you wouldn't get somebody who had a 60 percent vaccination rate suddenly changing their method of reporting and having

an 80 percent or a 20 percent vaccination rate. I know that unfortunately, the table that's in the Appendix E, which I know that you all probably didn't necessarily have to look at, and then there was a brief explanation of that testing in the Section 2(b)(5).

But we did look at that, and the results that we got suggested to our comfort that different sources of vaccination data would still produce acceptably comparable, although certainly not identical results.

DR. STANGE: Mike.

DR. STOTO: I just wanted to make the point that this is an issue. I think all the influenza vaccines, as indicated we're looking at, are probably beyond that as well. It's just an intrinsic problem.

DR. WINKLER: Just we do have the voting gizmos. Everybody's got one in their hand. We're going to vote first on the reliability, and then next on the validity.

You have the work group's initial ratings. So what we'll have you do, when Kristin starts the clock, is pick high, moderate, low and push the proper button, 1, 2 or 3, or 4 for insufficient evidence. This will be our trial, so --

MS. CHANDLER: I just have a couple of notes. So we ask that you please direct our remotes toward this computer in front of me. Once you enter your numerical answer on the keypad, you should briefly receive a green light. If instead you receive a red light or no light, we ask you to enter your response again.

You don't need to worry about a duplicative response. Only one response is tallied per Steering Committee member. And then finally, we do have the capability to revote if the Committee feels that another vote is necessary.

These are just examples to make sure that everybody's keypad is working. We're not

actually voting.

DR. SPANGLER: We have a process question. When we filled out the survey monkey already, does that count as a vote, or do we redo it here as an official vote?

DR. WINKLER: You redo it here, yes.

DR. SPANGLER: Okay, thanks.

DR. PACE: Right. But also consider that part of the voting is having you all together and raising issues, which could ultimately change your view one way or another too.

MS. CHANDLER: Okay, so one final note. There is a small blip in the system, and it's only allowing a ten second window for the vote. Can you all get them in in ten seconds? Let's try now.

DR. WINKLER: Okay, great. So we're going to vote for real this time on reliability. Ten seconds. Now.

Kristin, move on to the next slide. Okay, the next one is validity, and we're

going through this one individually, to see how this group wants to go as the exercise. We may be able to streamline this with subsequent measures. But on validity, you do see the ratings from the work group, the discussion from CDC on the voting. So go ahead and vote on validity.

MS. CHANDLER: Please vote again.

DR. WINKLER: The votes are 2 high, 11 moderate, 2 low, 4 zero, or insufficient or zero. Okay.

DR. STANGE: One abstention.

DR. WINKLER: Okay. In this particular case, we voted highly for reliability and moderate to high for validity. So it does pass the scientific acceptability criteria. So we're able to move on to the usability criteria, which is the extent to which intended audiences, consumers, purchasers, policymakers, anyone out there, can understand the results and find them useful.

This is where we ask about usefulness for public reporting. So again, just to go back and you've seen this slide before. The usability rating of the work group was high to moderate one. Comments that it's not currently reported, but there's a rule pending for CMS and the Joint Commission does require it for hospitals.

Linda, did you have any other comments around usability? Any other comments from the group? So we'll go ahead and vote on the usability.

The results are 10 high, 5 moderate and low is zero. Okay. So now we'll move on to the feasibility, and feasibility, I think, is some of the discussion you've had, the extent to which the required data are readily available, retrievable without undue burden and the measure can be implemented. I think these are some of the questions you have around data sources and collecting and having that data. So any discussion around the

feasibility?

DR. SPANGLER: Comment. One thing I noticed is 4(b)(1), which is under electronic sources. It seemed like a common answer for that was some data elements are in electronic sources. Then the next question is "If all or not, then you need to answer this question." I think that was never answered on any of the measures.

I'm not sure. Is that -- so I had this question on the call too. Is that insufficient, does that mean it's moderate? It seemed like nobody ever answered that question. I don't know if that's a process thing or the reasons for that. Do we know?

DR. WINKLER: Well again, I think you balance the various subcomponents of each of these criteria. But we are certainly trying to drive, you know, the development of the data systems, to make this much more feasible, by using electronic data collection. Certainly, some types of data will be more

advanced in that than others.

So it's not -- again, it's a subcriteria. It's not an all or none kind of thing, but you balance that subcriteria in terms of the overall question of feasibility for the measure.

DR. SPANGLER: So I guess my next question is do they not answer because they don't have an answer, or they just -- do we know? Do we have any idea?

DR. WINKLER: Can CDC respond to that question?

MS. LINDLEY: The question is there was a question about the proportion of data elements in electronic sources, and then there was a follow-up question that was unanswered.

DR. SPANGLER: It's 4(b)(1) and 4(b)(2).

DR. WINKLER: Correct.

MS. LINDLEY: So 4(b)(2) only appears if you give a certain answer to 4(b)(1). I think you said it was all or none, and since

we said some, the question didn't appear. It got skipped out. That's why we didn't answer it.

DR. SPANGLER: Then it's the format of the question.

DR. WINKLER: Yes. That's, and I didn't -- that's a new one for me. Thank you. We learned something.

MS. LINDLEY: I couldn't figure out how we would have missed it otherwise.

DR. WINKLER: Any further discussion on feasibility? So let's go ahead and vote on it. Yes.

DR. SPANGLER: So then would all categories in the numerator and the denominator, right? So it's collectively how do we think, and then do we think it's feasible or not? Yes, okay.

DR. WINKLER: Okay. It's high, zero, moderate 12, low is 3. Okay. So Kristin, what's the next slide. So this is the overall vote. This is the do we feel that the measure

has met all of the NQF criteria, and is suitable for endorsement. Any discussion?

DR. STANGE: And where do we put the caveats?

DR. BURSTIN: That's a separate thing.

DR. STANGE: Separate?

DR. WINKLER: 15 yes, 0 no's. So the group thinks this measure is suitable for endorsement. There were some caveats, there were some recommendations. Do we want to be sure that we have those captured appropriately? One was around stratification for disparities, that we'd like to see certainly by the time of their next endorsement cycle, that we want to see data for disparities, as have been discussed. What are the other caveats? Is that it? Is that the only one.

Okay, for both the workforce and the population. All right. So I think CDC is hearing that message, but we'll certainly also

follow up with them.

DR. BURSTIN: I'll put out that Paul's comments directly worked for that question of how does the measure translate to the community, so thank you. That's a good suggestion.

Measure 1659

DR. WINKLER: All right. The next measure on our list is 1659, influenza immunization. This is brought to us from CMS, and it is a measure for hospitalized patients. It is the inpatients aged six months and older discharged during October, November, December, January, February or March, who are screened for influenza vaccination status and vaccinated prior to discharge, if indicated. Is someone from CMS on the phone to introduce the measure? Keziah Cook, hello?

MS. COOK: On the home health CMS measure?

DR. WINKLER: This is inpatients.

MS. COOK: Then I'm not the right

person.

Measure 522

DR. WINKLER: Okay, sorry. Sure. We can skip to the home health measure, which is 522, and this is the percentage of home health episodes of care, during which patients received influenza immunization for the current flu season. So Keziah, it's now your turn.

MS. COOK: So this measure received time-limited endorsement in 2009, and we conducted reliability and validity testing based on data collected during the first nine months of 2010.

The measure was initially specified based on the consensus recommendations. So while the publicly reported measure reports the number of home health episodes in which the patient received a vaccine for influenza, either from the home health agency or from another provider, which the home health agency confirmed.

The additional measures of vaccine offered and refused or vaccine contraindicated, are also calculated and then reported to the home health agencies themselves. I can briefly talk about the reliability and validity testing, or if you'd like me to talk a little more about the measure in general, I can do that.

DR. WINKLER: I think Jason, you were the reviewer for this one; correct?

DR. SPANGLER: I was.

DR. WINKLER: Why don't you -- okay. Why don't you start with the discussion, and certainly the developers are available if you have any questions for them.

DR. SPANGLER: Sure. Because this one is different than the previous measure, I thought it probably would be good to bring up what you had discussed earlier, Reva, and that's this idea of a universal measure. If you look at all the 16 measures and now we have eight, a lot of the discussion we had in

the work group was why can't we have one measure that incorporates all of the denominators together, and so we won't have a separate one for home health, a separate one for inpatient, a separate one for different age groups, high risk populations, etcetera.

So I didn't -- we can maybe start with that discussion, what people feel about that, because that was one of the -- my comment on every single measure that I looked at on flu immunization was this should be incorporated into the universal measure.

DR. STANGE: Can we have some context for that from what are the possibilities for that happening, and how would that happen?

DR. JARRIS: Can we ask the folks from CMS, has there been a discussion between CDC and CMS about how that might be approached?

DR. PACE: I'd like to just put some context around it, because it's an issue that comes. I mean it's most dramatically obvious

with these measures, but it comes up in other projects as well, and part of it is when you start looking at those detailed measure specifications, you'll see there are some differences because of the data source. So that needs to be specified. That's not an insurmountable issue in terms of having one measure.

Probably the most practical issue is that currently, we have measure developers that specify or specialize in a particular setting or data source, and it's just been impractical to coax measure developers to create measure that apply to other settings or data sources, for which they don't have the knowledge or information about.

So if you have some suggestions about those things. But those are kind of the two practical issues that we keep running up against.

DR. STANGE: I wonder if the idea that care is going to be hopefully

increasingly be integrated, that you can make an argument that you're looking out for the end user who has this cacophony. I mean is that a lever point? Bobby's next, but do you want to answer that?

DR. PACE: Well, I think you're right. I mean there's, you know, the end user would love that, and NQF, you know, would certainly like to have that. It's just been a practical issue, and frankly that's why we ended up with those standard specifications, so that even if we had to have different measures for different settings because of the unique data elements, that at least they would be aligned.

I don't know if you're experiencing it here. In the original project, there were even more divisions of measures. So for example, physician measures for COPD patients, and then a separate measure for heart failure patients, and I think a lot of that has been resolved and combined. But the different

settings and data sources is still a continued problem.

MR. PESTRONK: I wanted Jason to understand what you're proposing, is would it be to retain? Well, I'll start from a different place. It seems to me it's useful to know what's going in the hospital, what's going on in the nursing home, what's going on in different settings, because they are different settings, and the process perhaps for making improvement in all those settings could be different.

So when you raise the question about combining them all into a single measure, I'm not sure I understood what would -- what that would look like, and would you lose the granularity of the current measures if you did that?

DR. JARRIS: Imagine a patient, though, who is in the hospital, would like to know their health care provider is vaccinated, who then gets assessed themselves and then

goes out to a rehab facility and then goes to home health care. Wouldn't it be nice if it was one measure, so that patient was measured the same way as they travel through the system?

Or even you could rely upon the facility transferring the patient to you for having measured that. That may not work in this system right now.

MR. PESTRONK: Is that a question of look, so in what you've just described, you still would want to know what the percentage was in each of those settings, right? So is it a question of then, when you say having a common measure, it's having a numerator and a denominator for each of those settings, so that one could do that?

It's not that definition of the numerator and the definition of the denominator would be the same in each of those settings.

DR. STOTO: So I mean it strikes me

that what you might possibly do is have the definition of the measure be the same in all those settings. But obviously calculate a different number for each one. But the problem is, though, that this one, this home health one, is based on episodes of care during the flu season, and the denominator would be different for other ones.

So maybe the numerator can be more standardized, but the denominator is impossible.

DR. SPANGLER: Yes. We can get to that later. That's another comment, about how it doesn't actually fall under the standard specifications.

DR. STOTO: Right. So maybe, you know, this one could be defined in the same way that a hospitalization could be defined. Okay. Right, yes.

DR. SPANGLER: I also think, I mean maybe this is what you were getting at, but you can stratify within the measure. So I

don't think you have to lose that necessarily. But if you want a whole -- we would have all these separate measures. How do you even compare who's getting vaccinated?

If you had a whole measure of we know the percentage of people who are supposed to get vaccinated. Here's how many are just total? Where I don't think we can do that at all now with the different measures. Where I think you can do that with a universal measure, but not lose maybe the individual type of measures. But I don't know. I mean is that something -- could we do that? Feasible, not as a practical.

DR. PACE: Well, you can suggest that, but I don't know if you're going to get any takers of the measure developers. I mean you don't have that measure in front of you, and I mean I don't know. It's something that we'd have to see. I'm just saying from past experience, we haven't found anyone that was capable of doing that.

DR. BURSTIN: And we do know on the hospital side, for example, CMS has been doing work on the CARE tool, which would allow that transition across the various settings. They are interested, for example, in at least trying to get the same data elements across the different measures, and ultimately if a CARE tool is available across that full set, that full continuum, that should get them closer, and I know they are working on that.

DR. SPANGLER: I think one of the measures, which we'll talk about, I guess, is trying to get close to that, which we'll talk about a little bit later, and trying to incorporate. I think isn't 41 trying to incorporate every outpatient into one? So I mean that's probably the closest we have right now.

DR. STANGE: Matt, you saw something that was relevant?

MR. STIEFEL: I hope so. So there was a slide on this question, right at the

beginning of the packet, about harmonization. It seems to me that the issue is can you harmonize the numerator, and then the denominators will be different, depending on the population. But if the numerator is the same, then you've achieved that harmony, and maybe that's the thing that we can look at.

DR. WINKLER: And recall that the prior attempts is to harmonize against that set of standard specifications, is a way of making it clear what a numerator should look like.

DR. STANGE: So is the NQF mechanism, then, to approve these, but give the measure developers three years to do the harmonization and come back, and then you decide what to do about it? Is that what would happen?

DR. BURSTIN: I think there's a difference between harmonization, meaning saying go back and try to at least align some of the key elements of the measures, and asking them to come back with a combined

measure. That's not something we can do in the course of our project.

If there are specific questions about dates of immunizations or something like that, where they could go back, potentially make a change and bring it back to you to harmonize, that's different. I think then really you can only evaluate the measures before you, and then make recommendations for additional measure development.

DR. STOTO: Well, to Matt's point, the standard specifications for immunization are like the ones we saw before about the numerator, that it includes contraindications and declines. There's no contraindications or decline here, as far as I see. So it's like it's inconsistent within the standard.

DR. SPANGLER: Actually, I would argue that it's -- the more inconsistency is the denominator, because the denominator is always for the standard specifications as number of persons, and this is not measuring

number of persons. This is numbering episodes, like you mentioned before, Mike.

DR. STOTO: Oh, so I assumed, maybe inappropriately, that if someone had two episodes during the flu season of home health care, they would only be counted once. But then maybe not. Because they do ask about, you know, if you have been vaccinated on the previous episode.

DR. SPANGLER: That was my big issue with this, and hopefully maybe the person from CMS, they can address that, because it didn't seem to follow the influenza immunization standard measure specifications because of the denominator.

MS. COOK: This is Keziah Cook. I'm from the measure developer, Acumen, and all of the home health quality measures are based off an episode of care, which is the period of time between the patient start or resumption of home health care, and their discharge or transfer from home health care.

So because home health care is a service that's provided over multiple weeks, this is the most sensible way to quantify, you know, what an episode is, would correspond to a hospitalization or something of that sort in a different setting.

DR. STOTO: But if someone had two episodes, say one in October and one in February of the next year, would they be counted in the database twice?

MS. COOK: Yes. In this case, they would, and the idea here is that the home health agency goes through a process, you know, each time they admit a patient to home health care, of assessing, you know, what are this patient's needs and what type of care do we need to provide to that patient.

So they do that once in October, the first time they begin treating this patient. When that patient comes back in February, they do that process again. Of course, our item, you know, one of the responses the agency can

give is we did not provide the vaccine to the patient this time, because we vaccinated them, you know, earlier this year or this flue season.

But it would be appropriate for the agency to document, during both episodes, that they confirmed that the patient had an up to date vaccine status.

DR. PACE: So this, I think this is an example of one of the issues about the unique, different data systems that are operating in nursing homes, home health agencies, hospitals, and is one of the current realities that we have to deal with, you know. So we can try to get things aligned as much as possible, but then we have to see about what's possible.

DR. STANGE: Bobby and then Madeline, are you up again? And then Paul.

MR. PESTRONK: Just a background question. If you recall, there was a name for someone who actually develops the algorithm

for producing the measure or producing the data, that nobody would own that process sometimes? So you're not able to get the data developed. What was that person called?

DR. WINKLER: Well, we have the measure developer, who conceptualized and specified and then tested the measure. So that's --

MR. PESTRONK: Okay. And then there's a question about whether anybody's actually collecting that. Once the measure's defined, it has a numerator and a denominator, someone has to collect that, which requires somebody to decide to do that, or to require that be done, right?

DR. WINKLER: Yes. They could be implemented by any number of potential end users. In this particular case, with home health, because it's based on the CMS OASIS data system, CMS implements these measures.

MR. PESTRONK: Okay.

DR. STANGE: So what we have here, is

because we have a fragmented system, and there's so many ways for people to fall through the cracks, we have a number of different measures that are for these different opportunities we have. That's the situation we're in.

DR. JARRIS: So in the National Quality Strategy, which is an HHS document, one of the six priorities is provide effective communication and coordination of care. One of the goals under that is improve the quality of care transitions and communications across care settings.

So we just heard from two different parts of HHS who put this forward as a priority. We didn't hear from them. But we've heard that well, they can't work together. I don't accept that. I think we go back with another recommendation to them, that the divisions in HHS, CDC for influenza vaccine among health care personnel, and CMS for hospitals and home health, sit down and

harmonize these measures across care settings, for the next time they come back.

It's the same umbrella agency coming to us. We should be able to say that we recommend you sit down and harmonize.

DR. PACE: I think the health care worker measure, isn't that for any setting?

DR. JARRIS: Yes.

DR. PACE: Okay.

DR. JARRIS: But still, I mean ideally, hospitals add up to the health care worker. Or are these patients who are saying --

DR. PACE: There is only the one CDC measure that covers all settings, I believe.

DR. JARRIS: That's really too bad.

DR. PACE: And then these are patient level, or you know, they're for the different facilities. But it's about the patients being immunized.

DR. JARRIS: Too bad. We need them for health care workers in those settings.

Okay.

MS. MERRILL: Is this the measure where it does list all the other measures that are similar to it? There's a place for them to do that, right? I know one of the measures did list about three or four of them that were similar to it, and that would be Paul's point. But I don't, I can never --

DR. WINKLER: Well, it would be the first slide I showed you, essentially would be the same thing, those eight measures. Except for maybe the first one, which was the health care personnel. But the other seven are essentially the same process of care.

MR. BIALEK: Is this the time to ask about contradictory evidence?

DR. WINKLER: Yes.

MR. BIALEK: Okay. So the Lancet article and the Cochrane Review are pretty compelling, that the impact is not demonstrated, seen as ineffective. I'm just wondering the measure developers, how that was

addressed?

MS. LINDLEY: Is Liz Madigan on the line?

MS. MADIGAN: So I'm not sure what your question is, in terms of how it was addressed. So when this was initially submitted there, I don't know if that information was included in the initial submission, because it was receiving a time-limited endorsement, and because the evidence has moved forward, I wanted to make sure that we included the most up to date information on the effectiveness of this.

DR. BURSTIN: It did specifically reference Lancet in the submission.

MS. MADIGAN: Yes, I did.

MR. BIALEK: Right, yes my question really gets to if the new evidence suggests that this is not effective --

MS. MADIGAN: It's very contradictory evidence. So it's, you know, and all the articles are different, of course, in terms of

what they include. It's the same issues we have with any systematic reviews or any of those kinds of issues about what gets included in the study.

So in some cases the study inclusions are different. I mean it's a hard body of evidence to evaluate, because you can't RCPs, of course.

MR. BIALEK: Right. I mean typically, the Cochrane reviews are pretty rigorous.

MS. MADIGAN: Right, exactly. I think the Lancet, in my estimation, the Lancet review was as well. So I think that if your question is are those both showing that these are ineffective?

In some respects, I think that is the case indeed what it's saying. At the same time, I think this is why the CDC has encouraged immunization vaccine among older people, and the manufacturers are now providing the high dose influenza vaccine for

older people for this exact reason. Does that answer your question?

MR. BIALEK: So, well let me see if I understand. The way I was reading this is that the ineffective was that having the individual vaccinated was not reducing hospitalization, was not reducing illness. It sounds like what you're saying is the strategy for getting them immunized has been ineffective. I'm trying to understand --

MS. MADIGAN: Oh yes. No, no. What we were trying to do was link this process for home health care to outcomes, and so if the outcomes that we were interested in were hospitalization, and I was trying to provide the evidence that in fact influenza vaccine does not necessarily reduce hospitalization.

MR. BIALEK: Okay. So the individual is vaccinated, and it does not necessarily reduce hospitalization. Okay, thank you.

DR. SPANGLER: It does.

DR. BURSTIN: It does reduce

hospitalization for influenza and pneumonia.

DR. SPANGLER: Right. It doesn't reduce hospitalization rates and deaths from respiratory disease.

MS. MADIGAN: Correct, correct, and that's what I'm saying, it's a complex body. So it's a complex body of research to try to synthesize in a succinct way.

DR. WINKLER: So any more comments on the importance criteria, which are the performance gap and the evidence?

MS. MERRILL: Is this the place to talk about why the population definition doesn't agree, because they're saying "all home health visits," but the evidence is only for elderly. So every home health visit is not an elderly visit.

MS. COOK: So the measure is specified to include those home health patients who meet the age and condition criteria. So it would be patients who are over 50 years old, or patients who have one of

a number of chronic conditions that, you know, the CDC recommends they receive annual flu vaccines.

So those are the patients who are included in the home health measure. Anyone who meets age or condition guidelines.

MS. MADIGAN: In addition, this is Liz. A large proportion of home health care patients are 65 and older, and depending on which source you read, it's somewhere between 75 and 80 percent.

MS. MERRILL: Yes, that is true, but you didn't state it. So you didn't state it in 2.A.1.1, brief measure information. So that's why I'm asking the question.

MS. COOK: I think if you read through the numerator specification and the numerator exclusions, I think it's the numerator exclusions where it's most explicit, that all home health episodes during, you know, the time period, are included, except those that failed to meet the age or condition

guidelines.

MS. MERRILL: Okay.

DR. WINKLER: Just, I'm just reading from the denominator exclusions, that say episodes in which the patient does not meet the CDC guidelines for influenza vaccination, and the CDC guidelines for influenza vaccination have changed, and do apply to everyone over the age of six months.

MS. MERRILL: Okay. So then you need evidence for why it's efficacious for more than just the elderly. Do we have that? Is that evidence there?

DR. STANGE: Well so I think we can just specify that that evidence exists, I mean, right?

MS. MERRILL: Okay.

DR. STANGE: I'm just looking at the number of measures we need to get through. I think we're, I'm really impressed at the ability of this group to switch gears just like that, and go from the big picture about

a new thing on population, to really incredibly detailed comments.

So I'm really impressed with the group, and I think we're learning about the process. We'll have to, I think we can go through this maybe one more, depending on how the time goes, and then we'll kind of reframe and think about how we're going to develop a process for getting through the others tomorrow. So Reva, walk us through the rest of this, please.

DR. WINKLER: So we've looked and talked about the importance to measure and report. Go back one, Kristin. So I think that the question is, voting on importance to measure and report. If we look at the evidence criteria, it was rated, sort of there was a bit of a split there, 1 low, 2 high.

The quality, split again between high, moderate and low, and the consistency was moderate and low. So Jason, did you want to have any further comments about the

quality, quantity and consistency of the evidence?

DR. SPANGLER: I don't think anymore than what you just said. I mean I think there is a difference. I think from my perspective, I think it was based on the reading of the evidence, and I honestly think there was additional evidence that they didn't submit, kind of what Kurt kind of mentioned, that we would agree that there is more evidence. So I kind of -- of the evidence they submitted, I think there is a certain level.

But maybe if you know that there's actually additional evidence, you may have scored it differently. But just based on what they submitted, I can understand, you know, the score, especially the low and moderate.

DR. WINKLER: All right. Given that, we really are going to have to get a sense of the Committee, in terms of how you're feeling about the evidence. I guess we can vote on those individually.

Kristin, can you back it all the way up? Yes, okay. Back up even -- oh, okay. Go one more past, one more. Come forward. There, all right. Did you want to vote on the performance gap of 1(b)? Why don't we go ahead and do that, and just everybody can get on the program here. So we'll vote on the performance gap.

That's 8 high, 2 moderate, 3 low. So generally the highs have it. Let's go on to the next one. This is the evidence decision, and I think we were a little uncertain on how people feel about quantity, quality and consistency. So Kristin, go on to the next one, where we have the consistency of the evidence, as presented or as you know. How would you rate that?

3 high, 4 moderate, 6 low, 1 insufficient. So it's 7 in the high-moderate, 6 in the low. Okay. So that's going to be more moderate there. Can we have one more?

DR. KINSINGER: Can I just be clear

I know what we're voting on? So it's consistency of the evidence that influenza immunization works in home health populations?

DR. WINKLER: Or in populations that --

DR. PACE: Basically in populations.

DR. KINSINGER: Right.

DR. PACE: I mean whether they're in home health or not --

DR. KINSINGER: It shouldn't make any difference, right.

DR. PACE: It's people greater than six months of age.

DR. KINSINGER: So I'm puzzled by the voting.

DR. PACE: Because it will affect every measure that you look at.

DR. KINSINGER: So we're just voting on --

DR. SPANGLER: Which makes this more confusing, because the denominator is not the person. It's the episodes. That's what I

think adds to your confusion, and to the confusion of people voting. Because it is, the denominator is everyone above six months.

DR. KINSINGER: Yes.

DR. SPANGLER: It should be, I think, but --

DR. STANGE: This is a good discussion for now, because as we go through the immunization measures, if we're going to stipulate that everybody six months and older benefits from it, that's the same for all of these. So we don't need to vote on this for each measure. Okay. We can revote this one.

MR. BIALEK: Can I just -- point of information or question. If we're not looking at the evidence specific to this measure, which is related to home health, that's what -- because the evidence related to home health is a lot different than the evidence related to does influenza vaccine work? Is it effective?

So I thought we were looking at the

evidence related to this specific issue of home health. That's not the case?

DR. PACE: Well, so what is -- so can you clarify what the difference is?'

DR. STANGE: Well actually it's a good point, because you can make an argument that if a person's really isolated at home, and the only people seeing them are home health workers who are vaccinated, they're at low risk. So you could make an argument there.

DR. JARRIS: They're still exposed to children and other vectors.

DR. BIALEK: The difference is what's presented in this information before us, and I know Jason mentioned that it was related to hospital admissions for respiratory ailments. The way I read what is presented, is it says both the Lancet article and the Cochrane Review both say that it's ineffective -- ineffectiveness of influenza immunization for influenza-like illness and pneumonia among

community-dwelling older people. It doesn't say that it -- I mean to me, that includes influenza.

So the research that's presented, the more current research from Lancet and from Cochrane, suggest that it's not effective.

DR. SPANGLER: I think you need to read that whole sentence. "It's ineffective in the prevention of influenza, influenza-like illness and pneumonia. It does not reduce hospitalization rates and death, but does reduce hospitalization for influenza and pneumonia, and reduce all cause mortality."

MR. BIALEK: I'm on page four or page five?

DR. SPANGLER: Yes. I'm on 1.C.14.

MR. BIALEK: 1.C.14.

DR. SPANGLER: On page five. The Cochrane says the same thing. "Well-matched vaccines were associated with reduced hospitalization from influenza, pneumonia and all cause mortality." So you're right. It

doesn't prevent this, but it does work on this.

DR. WINKLER: I think there was a desire to re-vote these, now that we've had this additional discussion. True? Okay. All righty. Any other comments before we do that? So we'll go back to the first question on evidence, and that's the consistency. So how do you vote on consistency? What's the matter, Kristin?

Okay, all right. The results are high 4, moderate 8. So that gives us the high-moderate rating that is needed. The next one, Kristin, is the quantity of studies. That's one we didn't vote before.

[COMMITTEE VOTING.]

DR. WINKLER: Okay. It's 6 high and 6 moderate, so it definitely is high-moderate there, and 1C is the quality of the body of evidence. You can vote on that.

1 high, 11 moderate, 0 low. So the moderates win on that. So if we go to the

decision, go back one. The quantity was moderate to high, the quality was moderate, and the consistency was high-moderate, so it does pass. Okay.

All right, next one. So overall, we've seen the evidence for performance gap, and we've seen the evidence. So does this measure -- no, we don't need this one. Yes. All of these criteria must be met. Go to the next one. Wait a minute. Didn't we have one that's yes and no?

DR. PACE: No. If it met those criteria, you don't -- I mean it's just going to pass.

DR. WINKLER: Yes, okay. So we do pass. So we'll move on to scientific acceptability of the measure properties, and here are the initial ratings by the work group. Jason, did you want to comment on scientific acceptability, before we vote on reliability and validity?

DR. SPANGLER: Probably only to say

that it's kind of similar to, it seemed like it was similar to the discussion we had on the evidence itself, that there was kind of a range, I think, depending on how people looked at it.

There are specific comments, if you look at the rationale. I mean there are specific points that people made, and again, the discussion about the timing of the episodes. Again, I think this again comes back to this issue, for me it comes back to this issue of the denominator not being a person or a population to these episodes.

DR. WINKLER: Did you have a chance to look at the testing results for the reliability and validity that they provided?

DR. SPANGLER: Did I?

DR. WINKLER: Yes.

DR. SPANGLER: Yes, I did.

DR. WINKLER: And what's your assessment?

DR. SPANGLER: I mean I thought

overall, I thought they were actually okay. I'm trying to remember what I voted. I think I voted moderate, but they seem to, from what I can recall, they seem pretty good, pretty detailed. Yes, I can't remember anything specific.

The one, oh I know one, actually one issue I did have is the proxies that they used. They used acute care hospitalization and improvement in dyspnea as proxies for somebody receiving the immunization, and that there would be improvements in those two outcomes for those who did receive immunization, and I'm not sure those were the best proxies to use. I think that's why I probably gave it a little bit lower rating.

DR. WINKLER: Okay. Any other comments on reliability?

DR. KINSINGER: I'm having a hard time seeing it, so are episodes of home health routinely reported? I mean that's a reportable, I guess because for billing

purposes? So that's a routine measure that's regularly reported, an episode of home health care?

DR. PACE: Right. I think you would think of it as being analogous to a hospital stay. It's just in home health, patients are seen for a longer period of time, you know, 30 days, 60 days, 90 days, and things are measured over that episode of care.

So it is about patients, but it's their unit of measurement, because that's how long patients stay in home health care. CMS may want to add something to that, but I think that's the reason that they're using episodes.

DR. WINKLER: Are you ready to vote for reliability? Okay, go ahead.

For reliability, it's 3 high, 10 moderate. So that's the moderate for reliability. So the next one is validity. Any discussion on validity? Comments, Jason or Linda? Anybody have any --

DR. SPANGLER: Sorry. I think my

previous comment was related to validity, not reliability. So sorry about that, the improvement of dyspnea and acute care hospitalization.

DR. WINKLER: All right. Any other discussion before voting? Okay. Let's go ahead and vote.

0 for high, 13 moderate, 1 is low. So moderate there, and both reliability and validity must be rated moderate or high to pass a criteria, and they were both rated moderate, so it does pass. We want to look at usability. Comments, Jason, on usability of this measure.

DR. SPANGLER: The one comment, and this was a question, I guess, for the developer was, there was no answers for usefulness for quality improvement, and I wasn't sure if that didn't come up, or there was a reason they skipped that.

MS. COOK: So I think we have an issue that NQF updated these forms after we

completed them. So I think there were just some items that didn't appear on the initial forms we filled out.

DR. SPANGLER: Okay, thanks. I didn't have any other comments.

MS. MERRILL: So what about this -- this issue may be not good to discuss now, but this idea of the relevance of these measures to immunization registries, if we're talking about relevance for population reporting. I don't know. I mean I think it's a longer discussion than maybe we have the time for.

But is there any relationship between this kind of reporting and what actually gets reported to immunization registries? It's just no relationship?

DR. JARRIS: Very few immunization registries are recording adult immunizations now. A couple of states are just beginning it, but I doubt they get at the level of home health care.

MS. MERRILL: So what's the answer

then? I mean I don't know if it's a general concept, that there should be some relationship or not. But you'll see that same comment on all of the immunization ones, and it's from me. Because it just seems to me that they're for public reporting, this is really how you assess population health. Not in the individual home health care agency; it's in the population. So that's something we might want to think about.

DR. BURSTIN: CDC does have a BRFSS survey item on flu vaccination for all, everybody. That's the population health one that we know of.

MR. COHEN: The question I had about that has to do with kind of again, the question of how the -- not so much the value of the data, but how the data informs action. I mean the value for me of something like home health versus overall population is that it gets a group of people to feel like there's something specific they can do to move their

numbers.

I'm not sure I fully understand that. But that's what feels really important to me, is that there are all these subgroups that we need to move their numbers on immunization, and in a way, just looking at the big picture, doesn't as well move the subgroups.

DR. STANGE: Jackie for you, would a population measure look different from an aggregation of the individual measures?

MS. MERRILL: That is one of the things that I wanted to talk about, and that's why I'm saying maybe now is not the time to do it. But there doesn't seem to be a link between what's going on here with this quality reporting, and then quality of the public health system in general, and I don't have the answer to how to create that.

But, you know, you've got two different people looking at it from a different point of view. It seems like there should be some efficiencies there.

DR. JARRIS: Well optimally, there would be a vaccine registry to use. But it's going to be a long time before we get there practically. But I don't think we could look at adding up these separate measures as an indication of population because hopefully, most people are not in health care. They're healthy.

MR. PESTRONK: So this an example of why the work that the three subgroups did today and eventually once they're adopted would be useful, to provide a structure for answering that question. Because what we would do is we would say okay, we have this clinical measure, which is what this is basically, and then we'd ask ourselves, walk ourselves back in the model, and say well is there some population -- is there some way to think about this from a population basis, and if there is, where is it appropriate to be thinking about that on a population basis, and what does it mean, then, to be thinking about

it at those different steps, right? Isn't that how we would have a structured way to think about clinical measures, as well as whatever we ultimately came up with on population.

MS. MERRILL: Right, but isn't that -- in terms of being aware of the situation -- you have an immunization registry that reports something, and then you have these other measures, and they have some relationship to each other, that tells you something.

DR. SPANGLER: Yes. From my perspective, it's more than just simply adding them up, because one of the things that was mentioned at the beginning of the discussion was that the population measures are not simply adding up individual measures. They're conceptually different from simply adding things up.

MS. MERRILL: So that's it. The idea of the situation so you understand. Well yes, we have an immunization rate of 80 percent,

but among these high risk populations, we know that these people are more at risk.

That's the kind of information that you need. That's what immunization registries give now, is just the global figure. But now we have all these different measures occurring and these people who are moving the numbers, as you say. So what's the situational awareness for the health officer or for the health authority for that jurisdiction or the country?

MR. STIEFEL: And you're right. It's a bit late in the day to dive in. But maybe we can put that on the agenda to talk about briefly tomorrow, is how does this fit into the context of the previous conversation? Are we interested, for example, in influenza or influenza mortality for a population? Then you could use the model to say okay, we've got a number of immunization rates for a bunch of different populations. What does that add up to? Not just in the cumulative immunization

rate, but in the mortality and morbidity associated with the flu.

DR. STANGE: So we'll put that on the agenda for tomorrow.

DR. WINKLER: So if we could finish up this measure, and see what you think about usability, if you're ready to vote. Yes? Let's vote.

The responses are 4 high, 7 moderate, 1 low. So that's a moderate to high rating. All right, and the next one is feasibility. Any comments on feasibility before we vote? No? You ready to vote? Let's vote.

4 high, 9 moderate. So again, a moderate. So we voted on all four criteria. The overall vote, does this measure meet the criteria to be suitable for endorsement? Any further discussion? Ready to vote? Let's vote.

Yes 10, no 1. The yeses have it.

DR. STANGE: Does the no person want to say anything, or protect their anonymity?

So this is when we open it up for public comment, because we're at 5:25.

(No response.)

DR. WINKLER: If you feel that that's the end of our agenda for today, yes, we should take public comment.

DR. JARRIS: Is there anyone on the telephone who would like to make comment from the public?

DR. WINKLER: Anthony, is there anyone who wants to ask a question?

(No response.)

DR. WINKLER: Anybody in the room?

DR. JARRIS: Very good. Well, that does wrap up our agenda for the day. I thank everyone for being here for a very long day, a lot of hard work. My mind is fried. I imagine some of yours might be also. Let's get home, get some rest so we can refry it again tomorrow.

DR. WINKLER: Yes. This is Reva. I just want to talk to the folks on the phone.

I know you've been waiting, and thank you so much for your patience. Again, the conversations went longer than expected. We will be starting again at eight o'clock in the morning. Please let us know if you're not going to be able to join us tomorrow.

Elisa and Kristin and I will be monitoring our email for any messages from you, and we'll see everybody tomorrow at eight.

(Whereupon, the above-entitled matter went off the record at 5:26 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 and Prevention Endorsement Maintenance

Before: NQF

Date: 09-13-11

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