NATIONAL QUALITY FORUM

Moderator: Elisa Munthali
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12:00 pm CT

Operator: Thank you for standing by. Welcome to the conference. Please note today's call is being recorded. Please stand by.

Elisa Munthali: Good afternoon everyone. My name is Elisa Munthali and I'm with the National Quality Forum and I'd like to welcome you to the Steering Committee's conference call. This is the Population Health and Prevention Endorsement Maintenance Steering Committee's conference call and this call is particularly on the committee's work on a framework for population health.

Before we get started, I just wanted to introduce some staff that are on the call with me as well, Kristen Chandler, Helen Burstin, and Reva Winkler and Robyn Nishimi. They're all working with me on the project.

Before I turn it over to your Co-Chairs, Kurt Stange and Paul Jarris, I just wanted to go over the agenda with everyone. And we will start off with welcome and introductions. I've been taking roll call as everyone has been dialing in, so it won't be anything formal.

But I will turn it over to Kurt and to Paul to do a recap of the committee's discussions on population health and the framework discussion particularly and to touch a little bit on the evaluation considerations that the other group will be working on.

From there we'll hand over the meeting to Los Angeles County, who I hope are on the call as well, and they'll provide an update on the analytics framework piece that they're doing and the paper.

In addition to that, we will talk a little bit about the upcoming call for measures and just simply show you an example of what we call a call for measures here and it - we're using the disparities project for that. And during the discussion, we'll also try to see if we can reach some consensus on definitions for population health, community, and shared accountability.

From there, we'll open up the lines for any members of the public or NQF that have comments on your discussions and then I will just give some next steps and then we will adjourn.

So with that, I will turn it over to Paul and Kurt to give a recap of your discussions on framework and evaluation considerations for population health.

Kurt Stange: This is Kurt. So at the two-day meeting we struggled together to make sense of kind of two very different sets of charges. One was to do the evaluation of 19 measures of clinical preve- existing clinical preventive services and immunizations that were due for updates and we did that work at the committee and there are some follow up items to that that we'll be dealing with on another call on Wednesday.

We began with exploring what the larger charge was, which is to help the NQF to do a call for measures of population health. They have a contract from HHS to support expanding into population health measures. And we had some group discussion of that. It broke into three smaller working groups for short meetings and decided that for working on that it'll be helpful going forward to have two smaller working groups.

One that was really looking at the idea of how do we think about population and community health, how do we frame this charge, this thing that we're trying to develop measures of? So this is the framework group that's here.

And I believe it was Matt who shared a model with us that he had been - maybe it wasn't Matt. Who shared the model again? Matt?

Male: Yes, Matt.

Elisa Munthali: It was Matt's people.

Matt Stiefel: Yes.

Kurt Stange: Okay. Thank you.

Matt Stiefel: And I'm on the call, so ((inaudible)).

Kurt Stange: Okay, good.

Elisa Munthali: Hi, Matt.

Kurt Stange: And I think we actually put you in charge this, didn't we?

Matt Stiefel: I'm not sure.

Kurt Stange: Okay. So there's this big framing thing that - and as I talked to the NQF staff they really - this is a new area for them and so help that we can give them on how to frame their call for measures and how to put this in context is helpful.

The other group that will actually be meeting on the call tomorrow is a little closer to the actual call for measures and that's called the Evaluation Workgroup. And that group's charge is to think more instrumentally about how do we actually measure population health.

For both these groups, I think recognizing this is a volunteer group of busy people, we thought that it would be very helpful if the work of the subcommittees and the overall committee could be informed from work that's been done by what's already been done in the literature, others that have thought about this and particularly by the environmental scan work that the LA County folks are doing as a part of their commission to paper.

So these two groups obviously have to work together thinking about how you frame, understanding population health can be certainly helped by thinking about how you would measure that. And obviously when we want to think about how we're going to do a call for measures you'd like some sort of conceptual framework.

The char- the contract from HHS really calls for measures of population health that's framed around certain health behaviors. And so that's probably a little bit narrower than the committee was thinking initially, but even if the charge is focused, you know, I think the group thought it would be helpful to nest that narrower charge inside a larger framework and we are thinking about how you develop measures of population health. And one of the things that came up in discussions, well, how do you define population, how do you define community?

So that's my summary of how we got to where we are now. This week we have three calls. We have this subcommittee, we have the subcommittee tomorrow, and then we've got the whole committee on Wednesday. And then the call for proposals actually is supposed to come up fairly soon, so there's a bit of a - bit of time pressure on this.

And I'll shut up for Paul or Elisa ((inaudible))...

Paul Jarris: Sure, yes, no, I want to welcome everybody to the call and acknowledge how much time everyone's putting into this volunteer effort because it certainly is a considerable amount of work and both conceptually and I think methodologically moving some new ground here.

The - I certainly agree with what Kurt said, that the framework is important to establish as we think about how the call for measures goes out so that it fits within some kind of a context.

Elisa Munthali: Right.

Paul Jarris: It's also very reasonable that we are struggling with this because there's no other group who's quite come up with a concise framework or definition yet. There are a number out there, each have something to offer over others, each capture a component that another misses. And at the - a region NQF meeting I was approached by (Ron Goldmann) from IHI who came up and said, you know, we're struggling at IHI with how to define population health and wondered if other groups could help them with that.

The same is true when I talked to the Center for Medicare and Medicaid Innovation and asked them how HHS conceptualized population health, they really didn't have a crisp formal conceptualization of it either.

So we are, in a sense, struggling with something that everyone is struggling with and no one has come to grips with yet. So it's important work we're doing. It's not easy. We may not get it perfect, but if we can move the ball down the field I think that that will be a big help for the whole field.

Helen Burstin: And this is Helen, I just want to welcome everybody as well and thank you for all your efforts. I just want to make one comment about Kurt's comment about the urgency of getting out the call for measures.

It's not so much an issue of an urgency that we, you know, we'd like to get it done quickly mainly because we think we really need to give the field sufficient time to respond. So it's really that at the front-end the sooner we can get out the ideas of what you would like people to start working on, the sooner the developers can consider whether they actually believe they could submit to NQF and we can work with them and provide some technical assistance to get those measures submitted.

So that's kind of the logic of it. It's not that the measures going to come to you right away, it's several months delay where we hope to work with the developers to have that happen.

Paul Jarris: So Helen, what - when - what is the - what are the constraints on time? Because, you know, it was helpful for you to send us the call for measure on...

Helen Burstin: Yes.

Paul Jarris: ...health disparities...

Helen Burstin: Disparities.

Paul Jarris: ...to look at it. It's fairly general, it's fairly broad, but it does capture...

Helen Burstin: Yes.

Paul Jarris: ...some conceptual...

Helen Burstin: Yes.

Paul Jarris: ...elements of it. I suspect that people can go outside of that, narrower or wider. But when you say it's helpful for them to have the time to get the things back, what are the deadlines, real or imagined, out there?

Helen Burstin: Elisa, do you want to go over at least what our tentative ((inaudible)) are?

Elisa Munthali: Sure. Sure. So this could change, and it probably will, depending on the work of the steering committee because we're hoping that that will inform the call to measures. And so right now the call to measures is due to go out at the end of October. We probably are definitely going to change that.

So that's what Helen was saying, that the urgency is not so much that we want to give the developers enough time to respond for you to come up with some of these general or broad requirements as you outline the ((inaudible)) tasks. So I would say probably a month from the end of October. I'd say towards the end of November. So that would give us enough time and give developers enough time to respond to the call.

Female: Yes.

Paul Jarris: Well when a call goes out is there - is that for a defined period of time before a developer has to respond? Does it close in 60 days or 90 days or something like that?

Elisa Munthali: Right and we've moved to a model, Paul, of trying to be more open-ended about that, so all we offer them is a deadline of when measures need to be submitted. That is why the more time we give them, we found the better it is.

Paul Jarris: And that's ((inaudible))...

Elisa Munthali: That's in - yes.

Paul Jarris: What - how long after the call goes out is that deadline?

Elisa Munthali: It's usually two to three months.

Female: Right.

Paul Jarris: Okay.

Female: Yes.

Larry Cohen: And can I ask a question at this point or should I wait?

Female: Oh sure.

Female: Go ahead, sure.

Female: ((inaudible)).

Paul Jarris: Go ahead, Larry.

Larry Cohen: I just wanted to go back to the comment about the contract with LA being a little restrictive in terms of behaviors. I remember at the meeting people said that it was - that the contract also there was fairly flexible and open-ended and I really am concerned about this behaviors

emphasis versus an environmental and community factors emphasis. And so I wanted to get a sense of the restrictions versus flexibility.

Helen Burstin: Yes, I mean, those three general areas -- this is Helen -- were arrived on with discussions with HHS and, again, because it was our first foray into this work we thought it would be helpful to have some guidance. But again, I think within those three areas anything is fair game. We certainly talked a lot, for example, about the environmental issues around access to food, healthy food, around obesity. So I think, again, it's - I mean, we've actually been having this discussion, it's - I think the scope in terms of the three areas is set, but I think the issue of depth and how you actually - the framework for what we're talking about in terms of measures I think is still pretty wide open for you guys to help think through.

Larry Cohen: So then I'd like to, you know, kind of re-encourage what came out at the meeting, which is really reemphasizing the depth being on the environmental side.

Paul Jarris: So Larry, there may be ways we can capture that in - some of that in our definition.

Helen Burstin: Yes.

Paul Jarris: Because I've come across a very - a fantastic - it's called Public and Population Health. It's a online textbooks the Canadians have developed for medical schools in this area and in it they actually clearly acknowledge, (and we) try to find the definition of it, that in fact behavior takes place within the contest of the environment.

Female: Right.

Paul Jarris: And they talk about blaming the victim. You know, so that if our definition captures somehow that this behavior can only take place in the context of an environment that enables it and promotes it and supports it, maybe we can get at it that way.

Larry Cohen: That's great. I'd love to see that textbook also, Paul.

Paul Jarris: I'll - I will send a link on to folks.

Larry Cohen: Thank you.

Female: Yes. Or just send it to Elisa and we'll get it out to everybody.

Female: ((inaudible)).

Female: So...

Male: ((inaudible)).

Paul Jarris: Yes.

Female: Great. That would be really helpful.

Female: All right.

Female: Elisa.

Elisa Munthali: Paul or Kurt, did you have anything else to add?

Kurt Stange: I'm good.

Paul Jarris: (Not at this time).

Elisa Munthali: Okay.

Kurt Stange: Yes.

Elisa Munthali: Great. Are there any other questions?

Sue Pickens: I'm a little confused. This is Sue.

Elisa Munthali: Okay. Hi, Sue.

Sue Pickens: Hi. Kurt laid out a schedule of calls that I don't seem to have. And I'm - this may be technical and we want to talk about it later, but I have the second workgroup on Wednesday, not...

Elisa Munthali: Yes, it's on Wednesday. It's on Wednesday, not on Tuesday. You're correct.

Sue Pickens: And when is the full group meeting?

Elisa Munthali: The full one is the day after on Thursday.

Sue Pickens: Because I don't think I have that on my calendar.

Elisa Munthali: Yes, so we'll talk offline, but in the original email they're all listed in there, the three meetings.

Female: Maybe we can just resend them around...

Elisa Munthali: Yes.

Female: ...so folks have them.

Elisa Munthali: Okay.

Male: Yes.

Elisa Munthali: So...

Kurt Stange: But may - but there are two working groups, so not everyone is going to be on the - both working groups.

Elisa Munthali: Right. And but there's some people who have volunteered to be on both and so what we're doing is trying to send information to everyone. Just in case. We don't want to discourage people from attending one group even if they have signed up for another.

Sue Pickens: And one other question. Are we going to - Mike Stoto just sent out some wonderful slides.

Female: ((inaudible)).

Sue Pickens: Are we going to look at any of those?

Paul Jarris: No.

Female: ((inaudible)) they're...

Paul Jarris: We have 45 minutes left, that's our challenge.

Sue Pickens: Okay.

Female: Although, again, I think, you know, everybody's seen them so we can certainly continue to have a conversation about them. If people haven't gotten them, we can send them around as well. They were very helpful, I agree.

Paul Jarris: Yes, they relate to the last item on the agenda.

Female: Yes, so...

Elisa Munthali: Okay, great. So I wanted to find out, operator, is Dawn Jacobson or Shivas Tricha on the line from Los Angeles County? Matt?

Female: Yes, operator.

Operator: Ms. Jacobson is on the line and her line is now open.

Elisa Munthali: Okay, great. Hi Dawn.

Dawn Jacobson: Good morning everybody.

Elisa Munthali: Good morning; how are you?

Dawn Jacobson: I'm doing just fine. First of all, thanks again for giving me the opportunity to share a little bit about the direction we're headed in with the scan here in Los Angeles. And as I mentioned with Elisa and Kurt on a call last Friday, we had a brief sort of powwow on approach, is I really do want to make sure that the key documents that you all know about end up on our scans. And so I'm going to start maintaining a list that we can post, Elisa, hopefully on the te- or the project site. But if everyone can assure that - ensure that I get those as soon as possible so I can see them and integrate them that would be great.

One thing I do want to assure Larry and others who do a lot of work within social determinants of health is that we - the vision of this has always been to put behaviors within the context of not just built environment but social environment, so that idea of a narrow maybe focused set of linkage that we can do within a prioritized behavior would definitely be put within a broader framework.

So that being said, there is probably three or four areas that I would like to, at some point later this week or early next week, send to the workgroups and the full committee as far as types of things we're going to start doing a pretty intensive scan on.

One is, as you've pointed out, definitions. And what's nice, I don't know if everyone's had a chance to see it, but Paul, I think you found a paper that (ASOs) doing that's really done a nice synthesis of the types of definitions that are currently out there. We'd like to pull together then, if there's any conceptual frameworks that these authors have pulled together, we'd like to find a depiction of that and be able to synthesize information from those. And so as soon as the Canadian definition is up and a bit of the conceptual framework, we'll work that in.

There may be more definitions than just population health, community, (flash) community health, and shared accountability, so if we could agree on maybe the content of the definitions, we laid out several in our scope of work that, you know, we'd probably want to add to that list. But if we

could then sort of agree that these the set of definitions we're shooting for then that would help the scan quite a bit.

Then in addition to definitions, there is - I think what I'm hearing emerging is (to do with) there's different frameworks around population health that may or may not be clearly defined. For example, in Healthy People 2020 they have a clear, again, depiction of how they see population health with evidence based intervention integrated within their, you know, 2020 release.

We'd like to do a scan of really, you know, sentinel documents around those types of frameworks. So I can think of Health People 2020, even the National Prevention Strategies that came out, certain AHRQ reports, certain IMI reports, and but to really get an idea on who's integrating social determinants with behaviors and then business processes or provider measures, you know, what's out there that we can integrate.

Then a lot of those reports of course are at the national level, but there's state level reports we'd like to give you sort of best, you know, gold standards or best examples. And the reason I think that's important is there's jurisdictions, government jurisdictions that have done a really good job of partnering with their healthcare systems and hospital systems to do an integrated community health assessment. And one of those jurisdictions in California is the San Diego Department of Health and Human Services. They co-fund and they plan together a series of population health metrics they agree they're working toward in their county.

So I'd like to be able to share that, you know, with the group and possibly other sort of gold standard examples at the state and local level that may or may not tie in measures. They don't always go to measures level. But I think if I can pull together a matrix and show you some key examples, you could then add others and we could move forward to the really good scan at that level.

Then within that scan it'll lead to the third task which is really then around pulling out measures, whether they're typical things that health departments have been going toward, you know, tobacco prevalence and whether it's a disease, you know, morbidity and mortality, behavior measure. But it's almost where I think if we go through some of these, again, key indicator sets so that county health rankings is one of those, certain state Healthy People plans, and even thinking of Trust for America's Health with certain measures, Commonwealth Fund.

I mean, go through those population health ones and link it to things like the AHRQ reports, certain (IM) reports around, you know, the ((inaudible)) measures. Just different types of then sort of measures that have lived in the healthcare arena at the national level, but then at the state level.

So there are certain states that have - or they'll do hospital compare with Medicare or they have their own hospital public reporting system. Look at what they've just sort of naturally been able to measure, come to agreement on, and then compare across their state. But then be able to pull together a set of indicators then that really are that whole linked set of linkages, upstream, social determinants, traditional populations' sort of health, community health measures then tie it to sort of what would be more internal to an organization for performance measures.

And then that leads to then the fourth to really then fairly quickly we can start pulling this together to give you some examples of ways we might then depict those linkages across that. I think someone on the main call talked about the, you know, the linkages or the - sort of the causal model that can come out these types of measures. And then be able to show you for tobacco, healthy eating and physical activity, some early depictions of how we think we can pull that together for you.

And then you guys can have a discussion on that. And that might be the measurement group actually, but get to some agreement that then the scan is leading to something very action-oriented within these linkage models.

And that is my update and I look forward to any questions that you have and any other insights and guidance you have.

Paul Jarris: Yes, this is Paul Jarris. I have a question. This is perhaps for the NQF staff. But I recall last spring spending an hour on the phone with I think RAND who had been hired again I was fairly certain by NQF to do an environmental scan of population health measures. Does anybody...

Female: ((inaudible)).

Paul Jarris: ...on the staff from NQF know about that?

Helen Burstin: No, Paul, this is Helen. I probably would know about it and I don't. RAND's done a fair amount of work for us. They did a cataloging of the various payment models out there, they've done some additional work for us on evaluation of the use of NQF (in direct) measures, but I have not heard them do anything on pop health.

Paul Jarris: Well I'm going to have to hunt it down though because I know I and my staff spent about an hour with them on it. Bobby Pestronk...

Female: ((inaudible)).

Paul Jarris: ...are you on the line? Do you remember the same - did you go through that also?

Robert Pestronk: I do remember speaking with RAND about that.

Helen Burstin: It may have not been - it may have been for AHRQ or somebody else. I - we can...

Robert Pestronk: Yes.

Helen Burstin: ...certainly follow up with RAND.

Robert Pestronk: Yes, I don't think it was for NQF.

Helen Burstin: Yes.

Dawn Jacobson: This is Dawn. I'm actually adjunct faculty at RAND. I could look into that as well.

Helen Burstin: Oh great.

Paul Jarris: Thanks.

Helen Burstin: Perfect, thank you.

Mike Stoto: This is Mike, Mike Stoto. Dawn, I think that what you described sounds very helpful, but one risk in doing a scan like this is you have big long lists without some kind of framework or a bottom line or some - identifying the commonalities and so on. That may be implicit in what you're saying that you plan to do that, but I just want to make sure that you - that we go beyond the lists.

Dawn Jacobson: Oh sure. Healthy People alone has hundreds if not thousands of measures, so...

Mike Stoto: Right.

Dawn Jacobson: ...it's more like - it's something that ((inaudible)) definitely has worked on. It's this idea that there's ord- like with this IOM report or different government, you know, or government linked agencies, they've done various priori- these prioritize - these various prioritization methods to get to a subset that might be of importance. And so within the context of the scan, we want to pull out did they describe how they prioritized these. For example, there's, you know, the release of the new leading health indicators for Healthy People that's going to come out. You know, how did these topic areas get in the national prevention strategy?

So, I mean, definitely we have to have a filter and I'm looking towards sharing really those things that have risen to the top. And so I want to do some sort of matrix for you so - to help, you know, the committee see this. But out of the ten organizations that prior - and like came up with a subset, what's on all ten, what's on nine of ten, what's on eight of ten, just to give you an idea of sort of what, maybe not by default, but what really thoughtful, intelligent folks - you've gone - you've all - all of you have sat on these various committees I'm sure. (SUSTA), you know, why did they prioritize certain things? I think if we integrate those reports we'll see things rise to the top.

Mike Stoto: Yes, I agree. But I al- but I think I had in mind something more like, you know, the fundamental distinction that people make between structure, process and outcome measures. What kind of distinctions are there like that in population health measures? And I think that the group...

Dawn Jacobson: Yes.

Mike Stoto: ...with the same can work. But I, you know, the thing I sent just a while ago, it tries to emphasize the difference between a shared responsibility for outcomes and accountability for specific actions, you know. So I think that's - that's the kind of distinction I have in mind. And there may be others.

Dawn Jacobson: Right, no. And I think that - and I know it's going back to the (top) that has sort of those two boxes, I think, you know, within the San Diego community health assessment, you know, there's sort of an agreed upon set. Like the ones that agreed upon are the population health measures.

What hasn't really been fleshed out is an agreement of an, you know, those linked set of sort of provider level measures. And so to me structure, process, and output, they don't end up at the population health level. You know, maybe that's something that we have to think about defining.

Mike Stoto: Yes, well, that's my point is that I think...

Dawn Jacobson: (Yes).

Mike Stoto: ...that we have to sort of think about a different way of categorizing measures like that. It's not a question of identifying which are the ones that show up a lot or on different people's lists, but just a different way of thinking about what kind of measures are there and are needed.

Matt Stiefel: Yes, this is Matt.

Male: ((inaudible)).

Matt Stiefel: I'm sorry, go ahead.

Male: So you...

Dawn Jacobson: So like, Mike, can you give an example of a structure measure at the population health level? Or a process one at the population health level.

Mike Stoto: Well I can, but I - but it's not clear to me that structure, process, and outcome is the right way of categorizing things at the population measures. So what I'm suggesting is there may be an alternative to categorizing in that - in those three categories that's more useful.

Dawn Jacobson: Okay. What I - great. And I - anyway, it just - Mike, if you want to have a talk about that separate - I mean, I do have a way I think with just linkages. I mean, it gets into the various types, (like) the list of things that measures population level that need to sort of be organized a bit. Yes.

Kurt Stange: Well this is Kurt. Isn't this actually the reason for this committee that the group felt that before we start diving into looking at existing measures we needed to have a way of - to seeing how they fit together and even if we're looking at a subset of measures that it would be - their utility would be greatly helped by looking at how the different - the multiple determinants of health at the population level fit together.

Female: ((inaudible)).

Female: Yes.

Larry Cohen: Yes.

Female: That's what it's for. Right. I mean, but - sorry, go ahead.

Larry Cohen: I'm just kind of thinking aloud -- this is Larry -- and I'm thinking about a couple of different issues. One, I'm just thinking about work I've done at different times on population change, for example, no smoking laws, and what we measured and what was available to measure and also the notion of contribution versus attribution, which I think is really important in terms of, you know, measuring what different groups are doing and how it contributes.

And, you know, and from what I've just heard, it struck me, which I've never really understood before, that while attribution (fundamentals) must be shared, there may be ways of defining very, very specific contributions in terms of short-term measures.

I do know when we did the first no smoking laws across the State of California that the way we measured them was by the reduction in tax revenues because that was the easiest and most available kind of standard material. And when we could see that the number of taxes for cartons of cigarettes dropped, we knew we were having an effect on things like cancer and heart disease. So obviously there need to be some links and some agreed upon perspectives that that's, you know, that less sales of tobacco would lead to that. And there could always be questions, well, what about pirating, et cetera.

The other thing I wanted, just thinking aloud, to add to this -- and Carolina and I were discussing this via email -- is that at the same time we're concerned about health measures I think we need to be concerned about equity measures and that we really want to link the two together.

The research we did a couple years ago on population based equity measures for the Office of Minority Health we think aligns well to health measures as well, where we identified ultimately 18 community factors, five of which were related to medical services and 13 of which were related to commun- to other community conditions, many were place, some were kind of equity and fairness, and some were kind of social measures.

And I just want to suggest that perhaps we look at those because we had those reviewed by national working groups and although they were primarily equity emphasized, as I say, I think they work really well for community factors as well.

Paul Jarris: Larry, with regard to the equity issues, I think it's absolutely essential we capture that in the definition, which...

Female: Right.

Paul Jarris: ...(Young)'s definition doesn't get. That's one of my problems with it. The other definitions put forward do. And we probably should be informed by what that call for measures that NQF put out around health disparity measures came up with and found, whether they had a conceptual framework and what kind of measures they got on that. Some of those may very well have informed our population health ((inaudible)).

Matt Stiefel: Yes, it's Matt Stiefel, I was going to comment on that too, is that disparities call for measures is not just an example, it may well be an important element of population health measures...

Female: Right.

Matt Stiefel: ...to the extent that we include distribution of health as one of our (the) elements of our definition.

Male: Yes.

Matt Stiefel: And, you know, I - well, just a couple of thoughts. One is I think that in terms of the definition, I know we're going to come to that in a minute, that three important categories are outcomes, determinants, and distribution. And it's important that we spend some time thinking about the distinction between outcome and determinants. Determinants have a long tail.

And, you know, it's - I'm not sure where you sort of draw a boundary on the determinants, but that distinction is quite important and we wrestled with it at IHI too in a driver diagram framework, what are the measures of outcomes of population health versus what are the measures of the determinants of population health. And those determinants, as we've discussed, can be quite

extensive and, you know, you can go further and further upstream. So I think it will be important for our work to make that important distinction.

Dawn Jacobson: This is Dawn. I think the fourth task where we start showing examples of these linkages and organization at the - at those levels, I - we can work that in.

Male: Great.

Matt Stiefel: Yes. Part of the reason I mention it is when we're talking about, you know, structure, process, outcome, the determinants can go to, you know, all the way upstream to the - all of the community factors, social and environmental factors in the community, and if you're talking about an NQF call for measures, the list can grow pretty long, pretty fast if we don't make a clear distinction between determinants and outcomes.

Larry Cohen: Yes, and often in equity related work, as I'm sure everyone on the call knows, there's the tension between kind of the underlying determinants of, you know, employment, eq- racial and ethnic equity, et cetera, versus community factors versus, you know, more proximate changes.

Dawn Jacobson: Larry, this is Dawn. Do you know good data sets that measure those? Because we did do a se- we looked at measuring social determinants within our jurisdiction here in LA and we found that there really aren't a lot of good data sources.

Larry Cohen: Well, I mean, it - again, it depends on what you're talking about with social determinants. But what I would say is that one of the reasons I got involved in this and one of the tensions for me in the entire NQF effort is that on the one hand there are - on the one - on - that the underlying determinants tend not to be measured and that we need to change our measures and that one of the most important statements I believe of this work is that we need toward different measures.

There are some measures in some cases and, you know, we can - probably it's best to discuss that a little bit more offline and for me to put you in touch with our staff that know more about that than I do. But on the other hand it really is not adequate and that's part of the problem. It's the old problem of people looking where the light is rather than where they dropped their keys. I think it's a big mistake to continue using inadequate measures, though I understand why from an NQF perspective, you know, that's more immediately easy to do.

Matt Stiefel: So it's Matt Stiefel again. Can - maybe I - can I ask NQF staff if you've given consideration to this distinction between determinants and outcomes? Because, you know, ultimately everything that happens to people over the course of life and everything that goes on in their physical and social environment has some influence on their health. And do you envision these measures of population health including both broadly the determinants of health as well as the direct measures of health themselves?

Helen Burstin: This is Helen, Matt. I think it's one of the main reasons we have this workgroup is I think we need some of your good thinking about what is the logical scope. I would think there are many determinants that would fit nicely. The question I think is really the - how broad do we go? Which is where I think, you know, your framework and just the discussion about scope from this workgroup would be very useful.

I should also add that a call for disparities is going out shortly, so we haven't actually gotten those measure in yet. And there was a commission paper done by Joe Betancourt and colleagues at Mass General that we'd be happy to share if people would like to see it.

Male: Yes.

Helen Burstin: It...

Male: Yes.

Helen Burstin: ...should answer a lot of these key questions. Okay. We'll make sure we send that around.

Matt Stiefel: We know that income and education are big determinants. Would you envision that income and education and the distribution be measures that arise through this process? As an example.

Helen Burstin: I would not think so, but I think it would be a good issue for the committee to think through that. I think mainly just because the question is are they - how is - I don't know. I think it's just a - it's such a broad concept...

Matt Stiefel: Yes.

Helen Burstin: ...how would it be used to access the accountability, I guess, or shared accountability, shared responsibility across a wide array of sectors.

Sue Pickens: Well this is Sue and coming from a public hospital, without taking income and education and housing status and social support into (affect), you can't hold people accountable for things that they have no control over. Just looking at readmissions, when we're discharging a homeless person with CHS...

Helen Burstin: Right.

Sue Pickens: ...we're held responsible for that 30 day readmission. So I think there has to be a way to figure that out.

Matt Stiefel: Yes. And I think you'd get no disagreement from people on the call.

Female: Yes.

Matt Stiefel: But in an NQF call for measure, the question is, you know, is - does the measure, the measure of the housing and income and education, or the health effects of those things.

Helen Burstin: Right. And I would assume it's more the latter in our context. But I think it's a discussion point certainly for the committee.

Robert Pestronk: Who are the - this is Bobby. Who are these measures that would ultimately be recommended by us, adopted by NQF if we're successful, be applicable to? Is it simply the healthcare sector that's paying attention to NQF or are there other sectors that are meant to adopt the measures too? Because I wonder whether the focus - that's one question.

And then the second is they - a ponder whether we're better off focusing on outcomes alone and because that's what we're interested in with respect to population health. How people get there is probably - are the probably experiments that need to be run so that some more uniform and consistent way of getting to those outcomes could be adopted in this very diverse American society. And maybe we shouldn't be specifying those at this point, other than recommending ones that people might want to pay attention to, and focusing our work on the outcome measures specifically.

Female: Yes.

Robert Pestronk: I'd reference also Richard Hofrichter, who's here at (NHO), wrote a preface piece for the United Health Foundation's report two years ago. And when he and I were discussing that one of the things that I mentioned to him was we need to include in there a list of potential metrics

that people could use. So that's another source that might be looked at for some suggested indicators.

Helen Burstin: Great. Okay. We'll definitely look at that. Do people want to talk about this question though? I mean, to me this seems like the purpose of this workgroup? Defer to you, Paul and Kurt, how you want to handle it.

Kurt Stange: What question are you talking to - talking about, Helen?

Helen Burstin: This is - I think the question of depth. Would the actual determinants themselves on their own potentially be measures or are they really in the context of the outcomes? And then I think the point that was just raised as well is that, you know, for whom are these measures intended? I think our understanding is that we're considering these to be fairly broad based. That these would be shared accountability, that they could be applicable at the state level, they could be applicable with shared reasonability to clinical entities, et cetera, but I think this is exactly what we wanted this workgroup to kind of help us think through.

Kurt Stange: Well the name of the committee, it says Population Health and Prevention, so the - there's no real pop - I mean, health - so these measures of tobacco, healthy eating activity, those are - that's not population health, those are in themselves determinants of health. So is the charge to also come up with a framework that would allow measuring actual - the actual health of the population and then look more narrow - then think about what are the determinants? And co- and then the call is about determining these particular determinants? Or is the name of the committee not part of the intended scope? Are we not really about looking at how you measure the health of a population?

Male: Yes.

Helen Burstin: I think the title is correct. It is about the health of a population. But I do still think the conversation we just had about determinants, while I agree smoking, et cetera, are determinants, I think we were having a broader conversation about I think the specific question posed was N- you know, would NQF bring in measures that assess the education and income, for example, of a population? So I think there's - I mean, this is I think part of the scope question.

Male: Yes, so...

Mike Stoto: This is Mike. I think that thinking about who will be the users of these measures, the uses of these measures can help to resolve this. And I - in the stuff I just sent out I originally had reviewed the Public Health Accreditation Board's standards and the new IRS community health benefits requirements and they both kind of lay out need to sort of measure community health status and about accountability measures, I think. And I think that if you just said let's think about the kind of measures that would be needed for those two purposes that might set the frame for what we should be doing.

Matt Stiefel: It's Matt, just to comment about how we've been thinking about it at IHI as well. So it's interesting to note that the initial framework handed to us and focused on behaviors and preventive services in fact are determinants of health and not measures of health, so already the - that initial framework was about measuring determinants. You know, in the IHI framework there - I mentioned we've clearly distinguished between measures of health and measures of determinants of health, and I think it would be useful for us to do the same thing.

And I guess, just to put a stake in the ground, I would suggest starting with the measures of health, which must have something to do with mortality and morbidity or self-perceived health and then the distribution of that in the community. Then clearly, separately, importantly, what are the contributions of the healthcare delivery system and the community and all of the other factors in

the physical environment to achieve those ends? But be clear about the distinction between the means and the ends.

And I think we're talking about the measures of health, which we have historically kind of conflated with measures of preventive services and healthy behaviors and thinking of those as measures of health as opposed to determinants of health.

Paul Jarris: I think United Health Rankings -- this is Paul -- takes that on by measuring both what they consider measures of health and then they have determinants of health and they measure both of them and from that they'll make a comment on, you know, the determinants of health are declining in this population and therefore down the line we expect the actual measures of health to decline or vice versa.

So measuring both of them simultaneously (would) be helpful. It - the de- measurement of health is something that should be useful to all parties. The determinants, it depends on who you are as to how you affect those. There's probably limited things a clinician can do about the education system, but there really ought to be things that the clinical sector can do in terms of other factors in leading to health in the community.

Larry Cohen: Yes, this is Larry again. I think we're conflating a number of things and for me it really goes back strongly to the question of who we see as the primary users of this. And I'm underlining the word primary. Because I feel like I always get in trouble when I say, well, everyone's going to use a certain tool or a cert- or in this case a set of measures.

I mean, for me, in listening to this, there are at least four levels of measures. There's the population health or the health of the sub population, there's the behaviors, or, you know, such as smoking tobacco, what used to be called the actual causes or still are called actual causes of death. For me there's the community environmental factors, and this what we worked on on

THRIVE, such as what's bought and sold in a community or the ability to get around or the look, feel and safety of a community or the social capital. And then there's the, you know, the educational status, the economic status, the amount of racism, you know, what some people call, you know, more ultimate determinants of health.

And, you know, and we could really work on any of those four levels. For me in the work I've done, I found the community determinants to be the most important because I do a lot of work with communities and that's where I think they can achieve the broadest change. I think that medical providers can and must contribute to that, which is the whole point, I think, of the community and population health work with places like the Center for Medicaid and Medicare Innovation, and would produce the largest change.

But again, I really want to go back to the audience question because I - I think to begin with we should be clear that there's, at minimum, these four different kinds of levels. And then, secondly, to say that what's most important is really audience dependent. Maybe even charge out the different audiences for different levels. And then the implication of that in terms of what we're trying to achieve.

Paul Jarris: Larry, this is Paul.

Male: ((inaudible)).

Paul Jarris: (In terms of) ((inaudible)) practical. I think that NQF's primary stakeholders have been the clinical sector...

Male: Yes.

Paul Jarris: ...whether that's providers, hospitals, insurers, and others. So we've got to address that. And if we could get the clinical sector to actually start looking at population health, looking at the behaviors of individuals outside of the four walls where most health decisions are made, and looking at community environmental factors, and use - and just the clinical sector use these things to start looking at that, that would be a major success and I believe it would necessarily reach to the - lead to the clinical sector reaching out to the public health and community organizations to help them achieve what they can't do alone.

So strategically, to me, that would be a major win, if we focused on population health, behavioral health, and community environmental factors and the measures were ones that the clinical sector could relate to, you know, and influence in some way.

Male: To me...

Paul Jarris: ((inaudible)).

Male: ...that suggests that - the IRS - new IRS community benefits regulations is the place to focus on because that really relates to the hospitals and it calls on the hospitals to collaborate with public health in these ways and the hospitals are the ones who know about NQF and understand what it means to have NQF endorsement of ((inaudible)).

Paul Jarris: Well, I see the community benefit as a major lever that hopefully we can take advantage of, but so is HETUS. I mean, health plans need to be looking at...

Female: Right.

Paul Jarris: ...this also and I think really responsible ones do.

Kurt Stange: This is Kurt. I'd like to get back to the charge of this subcommittee. So I think Matt framed it actually very well. The call for measures that will come out will be about a certain set of behavioral determinants of health. And in order to make that palatable, actionable and to really have an impact that is going to need to be nested within a larger framework that puts that into context.

And so the reason that this subcommittee was developed is before we develop a charge that is about behave- some - be- three behavioral determinants of health, we need to put that into a larger contextual model that says these are not health, these are determinants of health. And so the issues are how do you actually measures these at the level of the community and the population and then how do they fit within a larger conceptualization that really is about the health of a community or a population?

So Dawn has talked about doing an environmental scan about what the conceptual frameworks are. Matt shared one with us when we were actually together last. If this committee has that environmental scan about here's some ways of thinking about that and we look at those and say what conceptual framework makes sense for the charge of NQF to develop these measures of these really health behavior measures that measure the population level, but how could we nest that in a larger framework that then will help multi stakeholder groups and others to really start sharing responsibility for looking at the health of a population?

Ron Bialek: And Kurt, this is Ron. Multi stakeholders was key with what you just said and which I think gets to the issue of defining community. And I know we have various views on that and I go back to believing that it - that we should be looking at a geographic definition of community solely because of the need for the various players within a community to take responsibility and work towards certain influencers over the various determinants of health.

Matt Stiefel: And it's Matt. Kurt, I guess I would just maybe challenge what you described as the charge to this group and but maybe that's the correct - maybe that is what the charge was, but I'm concerned if our call for measures will be about selected behavioral determinants of health and may - perhaps preventive services. Just because I think that that will be too narrow.

Male: I agree.

Matt Stiefel: And I actually think that we can make a contribution and even if the contribution is focused on the behavior of the healthcare delivery system, if we provide clarity on measures of health outcomes. Because I think part of the problem with the healthcare system is that we have not had clarity or agreement about health outcomes measures.

And so instead we focus on utilization and cost and service, but relatively little on mortality, morbidity, self-perceived health, and the distribution of that health. And I think that if we had clearer articulation of health outcome measures, it might drive the healthcare system to focus differently than we have historically.

Kurt Stange: I agree totally with that, Matt, and that's what I was trying to say. I'm trying to reconcile that with what the NQF has a contract from HHS to call for at the end. And if we are able to have a call that's much more broadly configured that would be great. I'm trying to salvage something from this if the call is already predetermined to be quite narrowly about these three health behaviors. And I guess I'd look to Helen to...

Helen Burstin: (Right).

Kurt Stange: ...to help us with the scope question (today).

Helen Burstin: And I - and Kurt, I guess I don't view those as very narrow. I mean, they are sort of the major issues in health in our nation and I think you can still have outcomes around those, you can have more determinant oriented measures. I think it's really up to the committee. And I think we talked about this at the meeting, I mean, between obesity, physical activity, and smoking you're capturing ,you know, well over the ma- I would assume the majority of preventable illness in the United States. So I think...

Kurt Stange: But those are determinants of health. Those aren't measures of population health.

Helen Burstin: Something about the de- no, no, they don't have to be just the determinants. I'm just saying those are the general areas we have picked. That's all we've done. (Because) we said, we can't boil the ocean, let's start and say there's three general areas we're going to focus on. So I don't see any issues with what kinds of measures relate to those. I just think somehow those need to be part of a conversation.

Kurt Stange: So the committee could actually make recommendations that the health of a community population, perhaps geographically defined, be the starting point. That we actually look at measuring the health of a population.

Helen Burstin: (I think)...

Kurt Stange: And the call for measures could be actually about a - the health of a population.

Helen Burstin: That's the intent of this work, yes.

Kurt Stange: Okay.

Helen Burstin: But still I think the hope is that, you know, we can't do everything and is this a reasonable starting place. We could certainly go back to HHS. I mean, we felt strongly that this was just too big an area to do it all at once.

Male: ((inaudible)).

Helen Burstin: But again, you know, if you looked at preventable mortality, they would certainly fit given this topic area we've selected.

Male: ((inaudible)).

Larry Cohen: Excuse me, this is Larry. I just wanted to say I need to get off the call. I think I've made kind of my thinking clear and Carolina of our staff will stay on as well.

Robert Pestronk: Hey Paul, this is Bobby.

Paul Jarris: (Hi, Bobby).

Robert Pestronk: I have been keeping sort of a rolling definition. I sent out a definition for population health right as the call started which was based on the definitions that NQF provided and I've just been creating a different definition which is based on the discussion we've had.

Female: Great.

Robert Pestronk: And so if it's okay I'll sent that out because what I tried to do is capture what we're trying to do in this definition. And it seems to me that ultimately what NQF needs is whatever our definition of population health is and then whatever our request for measures related to population health is and maybe this will be helpful to the group.

Female: Great. Thank you.

Female: Happy to share it.

Paul Jarris: So we do need to start wrapping up. I think we just have a minute or two left.

Matt Stiefel: Hey, I wonder about this group, the framework group and what - are we going to continue?

Helen Burstin: Oh I think that's a question for you. I mean, I think one idea would be do you - would it be helpful for you to continue to sort of iterate on some of these definitions? Would you like to start actually trying to draft the scope? Maybe that - I mean draft the call for measures? That actually might be a useful concrete exercise that may make it a bit more clear as to what we're seeking.

And I guess the other question I have, Matt, is, you know, whether we want to actually talk about, you know, utilizing a specific framework like the one you had shared with the workgroup at the meeting.

Matt Stiefel: Yes.

Robert Pestronk: So - so this is Bobby. What I'll send out is basically that. It's five paragraphs, half a - not even half a page, which basically says what population health is, what it's inf- where it - what inf- what determinants - or what determinants influence population health and then it's what NQF's request would be for indicators of population health and the determinants of population health. And if that were coupled with a diagram, you know, however that were framed, either linear, cyclic, or Cyrillic, that might give us a - and anyone who is interested in submitting measures an idea of what we're interested in.

It seems to me that's what NQF wants to send out ultimately. Is that right?

Helen Burstin: Mm-hmm.

Matt Stiefel: So I think a framework is useful and I'm happy to continue to participate...

Helen Burstin: Okay.

Matt Stiefel: ...in this sub group. This is Matt.

Male: And Helen, let me ask you, would you and the NQF staff come up with something for the group to react to in terms of a call based on the definitions put forward based on what a population is in this conversation?

Paul Jarris: (Be great).

Helen Burstin: We'd be happy to give it a shot. I believe it's on the - I'm told it's on the next steps slide via my able staff here. So look at that. Staff draft call for measures. How prescient, Paul. Yes, so I think that's why I think some of these definitions will be helpful. Some of the scope questions. It's still a little fuzzy. I think we'll go back through as we kind of talk about this and digest some of the discussion and some of the framework from slides that are being shared around. But we'd be happy to do that.

And again, I think we're also going got have the input. Dawn's had this conversation with you. We'll be getting additional information from her that we can share with the group as well. I think the environmental scan actually would be very useful to also help crystalize our thinking about if you look at what's out there, you know, which of those do you think would be among the most important that we'd want to prioritize?

Paul Jarris: Okay. So I think Matt in response to your question, it would be helpful to have this group look at the - a draft call for measures from the point of view of a framework to see how we can flesh that document out as well as the measurement group looking at it from that point of view.

Matt Stiefel: Yes.

Female: Thanks, guys.

Paul Jarris: All right, well, I think we're at the end of our time.

Female: ((inaudible)).

Paul Jarris: So we'll have to just regroup and think about the next steps for the measures group, but it may very well be - well, I guess that we can have a report out to the full committee meeting.

Helen Burstin: Yes.

Paul Jarris: And following - and at that time discuss what the next steps for each of the sub groups are.

Helen Burstin: Exactly. Great.

Paul Jarris: Well, thanks everyone for your time.

Female: Thank you.

Female: Thank you.

Male: Thank you.

Male: Thank you.

Paul Jarris: Appreciate it.

Female: Thanks.

Paul Jarris: Bye-bye.

Operator: That does conclude today's call. Thank you for your participation.

Female: Paul.

Paul Jarris: Yes.

END