

NATIONAL QUALITY FORUM

Moderator: Elisa Munthali
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10:00 am CT

Operator: Please stand by everyone. Today's call is being recorded. Please go ahead.

Elisa Munthali: Thank you, Tom. Good morning everyone and welcome to the Population Health Evaluation Workgroup call. My name is Elisa Munthali and I'm with the National Quality Forum.

And also joining me from NQF are my colleagues Helen Burstin, Reva Winkler, Karen Pace, and Kristen Chandler.

Before I turn the call over to Paul Jarris and to Sarah Sampsel, I wanted to briefly go over the agenda for today and that's the next slide. Thank you.

We'll just start off with a brief welcome so that we can take a quick look. We will ask Paul Jarris to recap the committee on the discussions from - I think it was Monday - from the same work group's discussions.

And then we'll lead into our work today which is going over the evaluation criteria, looking at provider level measures and population level measures and seeing if there are any special considerations that we need to keep in mind for population level measures.

After that we'll look at an apparent example of a provider level and population level measure. And then we'll open up the lines for NQF member and public comments, and then I will briefly go over our next steps, and then we will adjourn for the day.

So with that, I will turn it over to Paul.

Paul Jarris: Thank you. Welcome everybody and appreciate your time. It's - everyone's giving quite a bit of effort and initiative to this and I think it's a very important opportunity for us certainly complex both conceptually and (methodologically) because NQF has not gone into the area of population health before. So we are trying to establish a beach head and move in a new direction. So thanks again for everyone's work.

The framework group met briefly on Friday and then talked again on Monday. And I think that there is an attempt by that group to come up with an understanding or a model if you will for how these measures could fit together from clinical measures through more population-based measures.

So there's a conceptual way of looking at it for people as often as I think people in public health may not necessarily understand a clinical measures and people in clinical care may not understand the need or the interventions in the public health population health arena. So the group is looking at that.

There was some question about really - again we're turning to what is the scope of this committee, and this group, and the timeframe and I think that's something we'll work to clarify.

My sense from that meeting on Monday was that it was a sense of let's put out a broader framework and then as we clarify the scope of this meeting we may have to narrow our work down. But at least we've established a broader framework for health public and - clinical and

public and population health can fit together and establish the notion that improving the health of a population is something we should be working on beyond just clinical services and the health of a clinical population. So that work will be ongoing.

I also want to say I appreciate the work you've been doing. We've been reviewing it and want to say we very much need this group to go forward. It sounds as if as we continue to work on is one of the first things we'll have to address is that the request or the call for measures that goes out. And it will be - the work of this group and the measures group will be very important in forming that document as we develop it.

And that will be some real work we can do if the staff can mock up a document similar to the one that you've either reviewed or will review on this call regarding health disparities. It will allow the field to take a look and respond with measures that we can then evaluate to see how they fit within the overall framework we've set.

So I'll stop there and turn it over to Sarah and thank you, Sarah, for leading this.

Sarah Sampsel: Well you're welcome. Elisa, did you have any other comments before we got started?

Elisa Munthali: No. Well what we can do is pull up the documents for ((inaudible)). I just wanted to make sure that everyone can see the screen at this point because we will be kind of going line by line, section by section so it will be helpful.

These are the same documents that were sent to you on Monday by email - an email that you should have received from me. And so the first one we'll pull up will be that evaluation criteria.

Sarah Sampsel: Great and while that's coming up just to set the stage and this was in the email that went out on Monday is I had a prep call with Elisa, and Karen Pace, and Kristen to kind of talk through what are the expectations of this work group.

And for me it's important when we kick off, you know, this call is to really think about what are the overarching questions and what is our goal. And so that went out on Monday and really what helped me think through this is the question of when reviewing this document that'll be on screen what - do the evaluation criteria for population health measures differ from patient health measures? And if so how?

And so in thinking back to our meeting, you know, there was a lot of discussion when we were reviewing measures about very specific items in a measure. And, you know, there has to be a differentiation between is it really a difference in criteria that we were calling out or is it a different level of understanding.

And so remember when it's clinical measures and those patient level or provider level measures, the measure developers are used to those criteria. I mean, they know how to write these. They have, you know, measure developers have their own language. They understand each of these criteria - well for the most part they understand them.

And so really the question is on the population health side do those criteria really differ or is it more of a language and an explanation type thing or a broadening of the definition. So as we go through the criteria that would be one thing that I would ask that everybody think about.

And then in addition if you recall at the meeting a couple of other things popped up as special things that we want to pay special attention to. And so as Elisa already mentioned looking at special populations and disparities and when we get to that section of the criteria, you know, are

there specific things we need to have in the criteria when considering the population health measures.

Data sources and do those differ for population health measures. And, you know, by data sources, we're considering things like survey claims-based data, you know. On the population health side, I think we're talking a lot more about registries and that type of data source.

Looking at the reliability and validity requirement, should testing differ, should, you know, there be different criteria for those options, also looking at evidence. And the specific question that was brought out at our in-person meeting was how population health measures might be correlated to the outcome of interest.

And as a reminder, the NQF criteria for outcome measures differ and don't have the same standard of evidence base that's required for process or structure measures, so keeping that in mind as we look at population health measures.

We had a lot of discussion at our meeting about accountability and, you know, when we talk about clinical measures accountability is typically at the provider level or the plan level or the hospital level.

So how does that differ in a population health or public health sector when really when you're taking care of an entire population of people, you know, there's more of a shared accountability. So does that change the criteria a little bit.

And then finally usability. And I know that Elisa in the email on Monday sent out the link to the task force draft report on changing of usability criteria. So just keep those things in mind as we go through this.

And Elisa, Karen, Helen, did I miss anything there?

Female: Sounds great.

Sarah Sampsel: Okay. So on your screen and depending on how you have your screen opened -- at least mine there's a little button on the top right that you could put maximize so if you're visually challenged as I seem to be getting as I get older -- you can actually blow up the screen a little bit.

And the - but the criteria are up there and these are the criteria that you saw when we were at our in-person meeting. They were also sent out on Monday. And Helen went through and made some updates to those criteria since our meeting reflecting those things that we ask to be done. You know, things like change the terminology away from patient because we're thinking about things differently in population health.

So is anybody is having problems pulling up the measure evaluation criteria on their screen?

Female: Kristen's trying to make it bigger for all of us.

Kristen Chandler: Okay. So it just got small again and I can't see again.

Female: Okay. ((inaudible)) works well too so.

Sarah Sampsel: Okay. So with that I don't - did anybody have time to look through this and have any feedback or considerations regarding the first set would be the considerations - the conditions for consideration.

The NQF proposal is that there's really not a strong need for change for most of these criteria until you get down to the bottom and that is - and we can't see the full page. But some discussion

around harmonization and what that language looks like in the population health arena. So any reactions to what's been provided?

Ron Bialek: Yes. This is Ron. You know, I was looking at B where you're saying no change and in B it specifically refers to the rate of clinical intervention. And I'm not sure that the population measures will be clinical.

Helen Burstin: Good point. I missed that one Ron. You're right. Thank you.

Ron Bialek: And then when we got to down to E in the harmonization piece...

Helen Burstin: Yes.

Ron Bialek: ...I'm wondering why the same language that was added to the population one - that same language. Shouldn't that also be in the other evaluation criteria?

Helen Burstin: About the concept of complementary, Ron?

Ron Bialek: Right. So shouldn't it be on both?

Helen Burstin: Yes. It's actually interesting and you see my comment. I'm not sure that's the right word...

Ron Bialek: Okay.

Helen Burstin: ...but I was trying to get a concept, but I think Paul brought it up at the meeting about not everything needs to be harmonized. But in some ways because they are so different they could give you a complementary view by having both of them.

On the clinical side to be honest, we really want them harmonized ((inaudible)) in class. We don't want to, you know, complementary from where we sit would be different measures in a clinical space.

Karen, do you have a thought about that?

Karen Pace: I mean, I think it's just to make it resonate with you. I mean harmonization depending on, you know, what levels you're harmonizing can be about complementary versus, you know, exact ((inaudible)). So it really depends on the measure and what levels you're looking at, what settings. So it's not - but it's not part of our process.

Helen Burstin: Yes.

Karen Pace: It's just, you know, what language we use so.

Helen Burstin: And if you can come up with better language, we'd love to hear it and we talked about, you know, there are times on the measurable (cap) data have been down and that would be more harmonization. Whereas I think sometimes there's measures that are truly very different, more community population oriented where harmonization doesn't make as much sense. They may look beyond smoking, but they wouldn't necessarily harmonize for example if they're kind of different conceptually. I'm not sure that's clear, but we'd be happy to add...

Karen Pace: And part of this is, you know, what we defined as harmonization and how we look at it is laid out in another document and so it's quite detailed which probably addresses some of your issues. But, you know, we just are trying to make sure that we have additional notes for your issues with these measures.

Paul Jarris: Ron, I can't find what you were referring to. You said something about some of the rates of services or something. Did I get that right - the first point?

Female: I think it's under rate of clinical innovation.

Ron Bialek: Right. B, it's on the left-hand column.

Female: Yes. We could just say rate of...

Ron Bialek: Right.

Helen Burstin: Innovation. But I (pulled) out all the patients, but I forgot clinical some times.

Karen Pace: And actually, you know, some of the things that we will do is to look at whether we want to go back and make any...

Helen Burstin: Yes.

Karen Pace: ...the major evaluation criteria more generic. That just doesn't happen overnight. We have processes for changing the criteria. But, you know, it's certainly something that we can, you know, for example removing...

Helen Burstin: Clinical makes a lot of sense for a lot of measures these days.

Karen Pace: Yes exactly.

Female: Okay.

Female: Sarah, back to you.

Sarah Sampsel: Okay. Any other comments regarding - and so, you know, I think the challenge for folks would be if we don't like the - or if we think we need more clarity under these then, you know, if folks want to kind of wordsmith a little bit and then send suggestions in NQF would be open to that. Okay.

So that looks like we're done unless any other comments on the first page, we move into the actual criteria for evaluation. And so on page 2 it starts with just the statement about what it means and I personally didn't see any problem with that.

And then moving onto impact opportunity evidence importance to measure and report. As an outcome of our meeting, Helen's made some suggestions and really, you know, and I remember from our meeting this was, you know, kind of very clear recommendations that we change number one to focus more on both health and healthcare quality to take it a little bit away from the clinical and make it broader.

And adding the concept of (determinance) of health and health outcomes and consideration of some of the variation, you know, may not be technically in the rates for a defined population but it could be geographic. So any comments, concerns about one?

Ron Bialek: This is Ron again. Just a suggestion is in the second line on the right-hand column where it says health and healthcare quality...

Female: Yes.

Ron Bialek: I'm thinking it should be or to be consistent ((inaudible)).

Female: ((inaudible)). Thank you.

Ron Bialek: Okay.

Sarah Sampsel: Okay. So then under 1A, you know, high impact which on the clinical side is defined as a specific national health goal priority identified by Department of Health and Human Services as a national priority partnership. I'm just wondering is there some leeway on that one to add the national prevention strategy?

Helen Burstin: Absolutely. I think that would make a lot of sense in this context, yes.

Ron Bialek: And do we assume that healthy people 20/20 is an HHS priority? Is that meant to be accomplished in that?

Karen Pace: No. I mean...

Male: ((inaudible)) add that in...

Helen Burstin: ...very specific. It's probably covered under the DHHS number. We'll go specifically and make sure it includes the national prevention strategy as well. Good point.

Paul Jarris: This is Paul. As I read through this, the concept of health disparities is captured in places here and one of the challenges is, you know, do you put it everywhere or where do you put it?

Female: Yes.

Paul Jarris: But this 1A after or where it says it demonstrates high impact aspect of health or healthcare parentheses large populations a substantial impact or smaller populations. To me this would be another critical area to say or as a source of significant health disparity.

Helen Burstin: Okay. That's a great idea. Put it right up front. I like that.

Sarah Sampsel: Other comments about that area before we move on?

Ron Bialek: Are we still in 1A?

Sarah Sampsel: Yes.

Ron Bialek: Okay.

Sarah Sampsel: Okay so let's go to 1B. In here we're talking about performance gap and again, you know, the language that was dropped in would be health or healthcare quality. This is one place Paul where disparities was dropped in. Are there other considerations on performance gap for population health?

Karen Pace: This is the area - disparities has always been part of this particular criteria so we are interested in looking at disparities.

Sarah Sampsel: I think my only concern here and I don't know how we deal with it is the fact that, you know, when we're looking at clinical measures we typically have a benchmark and we typically have something, you know, we're trying to get 100% or 90% or whatever. And if we were talking about, you know, the measure that we talked about at the in-person meeting which had to do with - now I'm blanking, it feels like Monday all over...

Female: It was preventable mortality wasn't it, Sarah?

Sarah Sampsel: Yes. So I mean what is the performance gap? You know, what...

Karen Pace: So typically when you're looking at performance gaps and opportunity for improvement, you look at variability across dividers because that generally gives you an idea that if you have variability and some providers are -- in this case if we're talking about population health -- some states or communities have better rates than others. So that gives you an idea that there is an opportunity for improvement.

The other thing is to look if there is overall concern about, you know, there may not be much variability but there's concern that there's high mortality or whatever the particular issue is.

But typically, you know, with outcome measures you don't necessary have a benchmark and the idea is to look at variability and see where there are still opportunities for improvement.

Sue Pickens: This is Sue. There are a couple of ways to look at it and tell me if I'm off ((inaudible)). One is looking at - using a reference group if you're looking at disparity. Like whoever is best as a reference group, then everyone else should aspire to meet that reference group.

Karen Pace: Right. It depends on if you're looking at - yes if you're looking at disparities that's absolutely what you're looking at is what's the performance by the various population groups that you're looking at.

Sarah Sampsel: Okay. So then I think my - where I'm getting hung up then is in kind this - kind of part of the last sentence of in the quality of care across providers in our population groups where some of these measures may not be measuring quality of care.

Helen Burstin: Okay yes.

Sarah Sampsel: And then, you know, I wonder if we need to expand to also drop in something population groups, you know, when we come up with the language around geographic and community.

Karen Pace: Well I think, you know, that's part of your - I mean this obviously is just kind of explanatory notes of how this applies to population health. And, you know, that's going to be kind of an overriding concept in terms of how you're defining population health and community. But, you know, obviously we can put that note in here that this applies to population health and actually we could just take out quality of care so.

Female: Yes that's what I was just trying to figure out...

Paul Jarris: But, you know, there's aspects of quality of care that are very relevant to population health and - for example, rates of immunization or reporting of reportable diseases or, you know, referring tuberculosis care for directly observed therapy.

So that, you know, if the overall objective is a healthy population and a population free of health threats there are specific clinical measures that integrate very well with that. And I don't think you'll find the clinical sector setting a quality measure around the rate - the percentage of reporting of reportable diseases.

Female: No.

Paul Jarris: But would population health and clinical medicine working together that can hit the radar screen.

Helen Burstin So is there another way to frame that then Paul so it's not just quality? So it sounds like there's a reason to consider quality of care, but it may not just a cross provider but is there a better term? Provider still seems very clinical-centric.

Paul Jarris: Yes.

Karen Pace: Well it says across providers in our population group.

Helen Burstin: But the population group just means a very ((inaudible)) group. I think he's still saying there are some measures about reporting and immunization that are more central to those who provide public health population health that may be very different.

Paul Jarris: It's provider health systems and public health systems.

Female: Aren't they providers?

Sarah Sampsel: And I wonder if, you know, in our conversation with LA aren't they talking about -- if I remember their definition -- there was something about three levels and I just wonder if that's the language...

Paul Jarris: Yes that's from the NQF national priority partnerships report to HHS on the national healthcare quality strategy -- it's always such a mouthful - in which one level was - and again that was preventative, it was clinical preventative services.

The second level was behavioral both measuring both patient behavior and the public health aspects of creating an environment in which healthy choices can be made. And a third level was population - was public policy and environmental change. So those were the three levels.

Dawn Jacobson: This is Dawn. Can I clarify that question?

Male: Oh please.

Helen Burstin: Yes. Thanks, Dawn.

Dawn Jacobson: Yes. So the idea that's coming out of the white paper is that to get a handle on defining different providers that a really nice way of doing that would be to keep healthcare providers in the healthcare system - like to measure that level of provider, then to call the governmental public health system through the public health providers. We call them sort of practitioners, but we can call them providers.

And then the third category that gets into the types of organizations that health departments commonly partner with in big coalitions and big, you know, health (and all) policies or determinants of health work that would be considered other. And so that could be transportation, you know, domain or education domain or social services domain. So it'd be helpful to keep those providers in those three categories.

Kurt Stange: This is Kurt. The other thing we want to think about is the part of the targets of this is multi-stakeholder groups. And so if we're thinking about just a public health providers or just clinical providers, we might be excluding measures that gets others involved that are involved in social determinants of health. So we might want to not over define this with the word provider of any kind because that really starts to limit the focus of the multi-stakeholder groups.

Dawn Jacobson: I guess again to clarify all those other stakeholders end up in their category which we can organize in a way that makes sense to the audience who will be using this. I'm not putting all those other providers as public health providers. But let us know sort of what word you want to use for those specific categories and we're happy to work that in.

Female: Sure. That makes sense.

Female: Very helpful. Okay. Sarah?

Sarah Sampsel: Okay. So if we're right - okay. So there's some work to do there, but if we move on to 1C (in) about evidence. And here is where numbers (or) outcome measure the evidence support might be a little bit different. But so the changes are in red, so health outcome, health determinants in our health outcomes in the population to strategies to improve health or healthcare. So that's consistent with prior language.

And then, you know, definitions of intermediate clinical outcome process and structure, experience of care where it was broadened and changed from patient. And Helen has a question there about should we also include something or should the language be more around access to care. And then the language for efficiency is proposed to stay the same.

Male: Well we should pull the word clinical out of intermediate clinical outcome ((inaudible)) intermediate outcome.

Male: Right.

Female: Yes.

Male: Yes.

Female: I just wasn't sure I could think of any policy to be honest. But maybe ((inaudible)).

Karen Pace: This is Karen. My question is how do you define health determinants and do we really need to accept those from having evidence because the reason that they're considered health determinants because they are linked to health outcomes. So are they more like - so what's an example of a health determinant? Is that more of a process or is it an intermediate outcome? What's an example that you all are thinking of as health determinant?

Male: First of all, I was just commenting. The word clinical should come out of there. Intermediate outcome still be there, but.

Female: Yes that's fine.

Male: But there are plenty of intermediate - I mean it depends on what you to consider. For example having a tobacco tax that's at a certain rate is an intermediate outcome if you will because it's been shown to decrease initiation of smoking and quitting of smoking. Clean indoor air laws for example are another example.

Karen Pace: Those would really be kind of interventions, wouldn't they - actions or interventions?

Male: But the measurement of whether a community has those things.

Karen Pace: That would be a structural measure.

Ron Bialek: Well a determinant whether or not somebody's smoking is - I mean smoking itself is a determinant itself.

Female: Okay.

Ron Bialek: And so the strategy is...

Female: So I don't...

Ron Bialek: ...the tax or other intervention.

Female: Right.

Karen Pace: So I don't think we'd want determinants with health outcomes saying that there should be no evidence that it is related to a health outcome, right?

Paul Jarris: I think there's lot of evidence if you look in the community.

Helen Burstin: Right and I lumped those together here. And I must admit I didn't through the ramifications that by lumping it would help outcomes as sort of a path on evidence. So I guess Karen's question here is does that make sense you're your health determinants be pulled out separately where there would be an expectation of a relationship to outcomes expected.

Ron Bialek: You know, I have a general question about this whole section. It would seem like this is the place where the HHS quality -- the AIMS -- could be referenced. I mean it would seem to me that the population interventions should at least consider the HHS AIMS.

Paul Jarris: Yes that's a good point, Ron - because we don't do that anywhere else.

Ron Bialek: Right. It doesn't have to meet every one of them, but at least it should be considered and one should address which AIMS the measure hits upon.

Helen Burstin: Right. Okay we'll see if we can work that. Some of them it's kind of a blend of content areas and strategy. I was just actually looking at it right before our call this morning. So let's see -

we'll see if we can specifically reference it in a footnote in that. And was it specifically around interventions Ron? Is that what you were making the point?

Ron Bialek: Well it strikes me that the AIMS should be explicit in here. They shouldn't even be footnoted. That we should know whether the measure is a population center. Is it equitable, is it proactive, is it risk reducing, etcetera. That that's something that I would think that the committee would wish to consider and that the proposer of the measure would wish to address.

Helen Burstin: Okay. We'll figure out where best to put that. I think that's a really good point. Thank you.

Dawn Jacobson: Hello. This is Dawn. Can I clarify one or answer one question that someone had earlier about strategy versus provider level measure?

Helen Burstin: Yes, please.

Dawn Jacobson: The type of measures that we have in LA, we consider those tobacco taxation measures, clean under air laws, we consider it a policy strategy. But we consider that a performance provider level measure for our health department so that we'd be working on that as our mission.

In the same sort of geopolitical area that a healthcare system would be working on getting tobacco cessation, you know, ask advisor referral with every inpatient in their hospital. So we would consider that complementary toward improving the determinant of health tobacco prevalence in our geopolitical jurisdiction.

Helen Burstin: Very helpful.

Kurt Stange: One thing that's important is to not limit it though to just public health or just a mission providers. For example one determinative health would be the percent of high school graduation. And so if you just limit it to public health and clinical providers you really limit the potential impact on multi-stakeholder groups that can really start looking at these tradeoffs across different sectors.

Dawn Jacobson: Was that Kurt?

Kurt Stange: Yes.

Female: Yes.

Dawn Jacobson: Hi, Kurt. My response to that would be if we keep those three sort of categories of providers, we would add that probably in a population outcome at that level or however you guys would want to tie that in at, you know, and then we would assess that as a provider level measure plus minus stakeholders in that other provider category.

Kurt Stange: I'm actually concerned about the word provider. It could have the unintended consequence of linking people in their heads too closely to healthcare.

Dawn Jacobson: Just for now I'm using that, but we can change it. But I just want to show you that we can add that in and measure it.

Karen Pace: Can we go back and get some comments, other thoughts about health determinants and does it stay under health outcome? I mean I personally think it could come out. You know, I agree that, you know, when thinking about health determinants there should be evidence that it contributes to a health outcome versus affecting it from meeting a different level of evidence.

Paul Jarris: I guess I see what you wrote here as being parallel to what's over on the other side:

((inaudible)) supports relationships of health outcomes and (process of special care). Isn't this just translation - the direct translation of that?

Female: Yes.

Female: I think the only issue Paul is I lumped in health outcome/health determinant which I didn't mean to do. I think the point we were just talking about is yes I think the health outcome now gets the same path regardless as it does for regular measures. But that health determinant probably should be pulled out as a separate bullet where there is an expectation of evidence that it influences the outcome.

Paul Jarris: Okay.

Helen Burstin: Yes.

Paul Jarris: Well if that increases the emphasis on health determinants that's probably good.

Helen Burstin: It does.

Male: Yes.

Sarah Sampsel: Okay. Any other comments in this one C area and, you know, so it's pull out health determinants, remove clinical from intermediate, anything else in that area?

Ron Bialek: Yes a couple of things - the footnotes 4 and 5. I'm not sure that number four is really appropriate for what's in this right-hand column. And then number five it would be I think appropriate to reference the guide to community preventative services.

Female: Oh the separate one. Okay.

Ron Bialek: Yes.

Female: Oh okay. I must admit I never went back and looked at the footnotes.

Ron Bialek: Okay.

(Crosstalk)

Ron Bialek: Then under the next bullet where it says experience with care could it be experience with intervention or strategy or something other than care?

Helen Burstin: Yes. I was stuck. I honestly couldn't figure out what to call it. So your advice here would be helpful. Strategy intervention is that - does that sound...

Paul Jarris: This is where the AIMS that Ron referred to before play in I think.

Female: Okay.

Karen Pace: Maybe it's not relevant. Maybe experience with care is not - I mean experience with care is about experience with care. It's not relevant in population health.

Female: All though it's interesting, you know, some of the recent measures we endorse around child health quality came off the National Children's Health survey which were a population over measures and it was clinical surveys about their access to referrals when they needed it or access to - so things that that field population health, right?

This is why I was trying to ask the question of whether sometimes is it also access. So, you know, some of those questions are actually more about experience getting access. Maybe it's just patient surveys and not worry about it.

Sarah Sampsel: Well, but I mean I would add to that. I think access is key as well as, you know, if you look at the art quality and disparities reports they talk a lot about communication and understanding. And those really are population health-based measures that impact disparities differently.

Helen Burstin: Okay. Right. So I'll play with that a bit.

Paul Jarris: So it's the notion of - I think the label is wrong, experience with care. The concept is a good one.

Female: Yes.

Paul Jarris: It is to measure something. That's important?

Female: Yes.

Paul Jarris: So we have to label it something differently.

Female: Okay.

Paul Jarris: Something like, I don't know it's almost like community value. I don't...

Helen Burstin: Or community voice or something. We'll think about it. Send us notes if you have ideas. I don't want to hold this up, but that's really helpful.

Sarah Sampsel: Okay. So like Helen ((inaudible)) you'll go back and look at the footnotes as well so we don't need to spend more time on this.

Helen Burstin: Okay.

Sarah Sampsel: Okay. So we're on to reliability and validity and again this was a section that the full steering committee thought we should pay special attention to.

You can see from the updates from our meeting that, you know, just changes were made as were suggested at the meeting as special things to pay attention to. Did anybody identify anything else in their review that we need to discuss?

Ron Bialek: Ron again.

Paul Jarris: We're now using - introducing the concept of community health as opposed to population health. Do we want to do that or...

Helen Burstin: That was the term people used at the meeting so that's why I threw it in here. But again your thoughts would be welcome. I think this is one of those definitional issues that we're still struggling with at the meeting.

Paul Jarris: Right.

Helen Burstin: But the community concept was that it is that shared accountability and maybe I just didn't capture it right.

Karen Pace: But I mean -- and I don't know where you're going with this -- but is our population and community use interchangeably? Is population considered - are communities considered different types of populations? So I guess it depends on what we think is the broadest term and if population health is that then maybe we just use that consistently through here. I don't know.

Helen Burstin: Whatever your preference guys.

Sue Pickens: This is Sue again. And I do think we were struggling with that definition and I don't use those terms interchangeably myself.

Paul Jarris: How do you use them?

Sue Pickens: Well - oh, I'm sorry about that. When I am looking at population health, I'm more looking at patient registries, populations of diabetics. When I'm looking at community health I'm looking at geography, and neighborhoods, and the health of my community. Does that make sense?

Paul Jarris: that makes perfect sense from a clinical point of view, yes. And that's exactly the wrong -- because I use those words very differently which is exactly what our problem is with all these terms.

Helen Burstin: Right. How do you use them, Paul?

Paul Jarris: I would say population health is a much broader concept.

Helen Burstin: Okay.

Paul Jarris: i.e., population may - may be the population of people within a jurisdiction, within a region, within states, within the nation. A community could either be a geographic location or it could be a community of people who have qualities that are lumped in some way or affinities to each other within a larger population.

Helen Burstin: Okay.

Paul Jarris: But I don't think we define the word community. I think it's used - mean many different things.

Sue Pickens: And I like Paul's definitions better than mine.

Helen Burstin: Okay.

Karen Pace: So can't...

Helen Burstin: ((inaudible)) community. What about if it's just a ((inaudible)) for health?

Karen Pace: Well what I'm wondering is couldn't it just say across organizations or populations?

Helen Burstin: That would be so radically simple.

Paul Jarris: Well the simplest thing is what somebody just suggested - population or entities with shared accountability for health.

Helen Burstin: Yes.

Paul Jarris: Remove community.

Ron Bialek: Right.

Helen Burstin: That was me. Okay. We'll try that for now.

Karen Pace: So what's making me think further here is, you know, the statement about EHR measures specifications. Is there anything translatable -- and I guess this is to you Paul and Kurt who might be doing more population health stuff -- is there anything similar we would need to consider on the population health side?

Paul Jarris: If this is implying that this should be limited to EHR that cuts out a lot of data.

Helen Burstin: Yes I know. And I expanded it later. I think I may have missed it here. Yes. Later you'll see I added in HIEs, I added in data sets without specifically being EHRs. ((inaudible)) accountability across electronic ((inaudible)) or something like that.

Female: Well...

Paul Jarris: It may be beyond electronic. It could be survey, it could be...

Female: This is specifically about EHRs because they have to use the quality data model. So if there are going to be no population health measures based on EHRs then we just take that out altogether.

Helen Burstin: (Yes) maybe for now.

Paul Jarris: Okay.

Karen Pace: No but I'm wondering since it's also kind of used as an example if, you know, something translatable is registries. And when your talking about registries I believe the nomenclature is HL7 criteria.

Paul Jarris: What if we drop this to a footnote?

Female: Okay. We'll figure that out.

Sarah Sampsel: Okay. So then we're on to 2A2 which is about testing before we get into validity. So any other comments about reliability that we need to make sure is brought out in these criteria for population health measures? Okay.

And so, you know, I think that makes perfect sense because reliability and validity are standard, you know, definite statistical definitions that, you know, need to translate no matter what type of measure we're looking at. So anything in validity that needs to be strengthened or called out more when we are considering population health?

I'm just wondering under 2B3 should it say - although clinical evidence is correct, I think makes sense on the population health side too. Just kind of noticing where we have clinical and make sure that it makes sense.

Female: Or just remove it and say evidence.

Paul Jarris: Right.

Ron Bialek: Right, yes.

Helen Burstin: 2B3.

Sarah Sampsel: Okay. Anything else in validity, Ron?

Female: Clinical - just take out clinical.

Ron Bialek: I'm cool.

Female: Say evidence.

Sarah Sampsel: Excellent. Okay. So we're on to page 5 of 9 with 12 minutes to go.

Female: ((inaudible)).

Sarah Sampsel: And, you know, here we're still under validity. And this is where I can see clearly that the term patient has been pulled out on the population health side and there was stronger preference or nomenclature around variation across populations, which is what we've been looking for on the population health side. Anything else jumping out at any anybody that needs to be ((inaudible)).

Ron Bialek: A couple of quick things and just to consider for 2B5. On the right-hand side where you have measure for the identification and statistically significant and practically/clinically meaningful, I'm wondering if we could potentially change that to measure allow for the identification or statistically significant and meaningful differences...

Female: Yes.

Ron Bialek: ...performance of variation (and of course) population in improving health.

Female: I like that.

Helen Burstin: Yes. In doing that you also remove the clinically piece, right?

Ron Bialek: Correct.

Female: Okay got it. Thank you.

Ron Bialek: And I'm looking at 2C on disparities. If we could change that to say if health disparities and then get rid of in healthcare, health disparities have been identified.

Helen Burstin: Okay.

Ron Bialek: Or health disparities - well, (no). Just health disparities I think would work.

Helen Burstin: Okay. ((inaudible)) capture healthcare disparity.

Karen Pace: We're actually going to be taking that out of there anyway remember?

Helen Burstin: Yes okay. Thank you. ((inaudible)) moving faster.

Paul Jarris: Can you explain the or under 2C disparities? No option for justification or lack of stratification.

Karen Pace: Naturally, we're going to be probably reworking this whole thing because we have a disparities group and we're really moving toward identifying measures that can be used to measure disparities versus - in really very few measures come to a specified for health disparities. And we're going to start looking at which measures should be identified. Helen, I don't know if you want to say anything more.

But this criterion hasn't been working very well so for some of the reason that you've talked about.

Paul Jarris: Let me just say having come from a rural environment if - in certain geographic areas if we did stratify by race we would be identifying people.

Karen Pace: Right. The small number issues...

Paul Jarris: Yes.

Karen Pace: ...you're talking about.

Paul Jarris: Yes.

Karen Pace: You know, and that can happen even in larger areas depending on what you're talking about. You know, if you're talking about rare events or rare processes, you know...

Paul Jarris: Right. You're right.

Karen Pace: ...you can have that issue for a variety of reasons. So I think we're actually going to be moving - kind of taking this criterion out and working in whatever the disparities the steering committee recommends.

Paul Jarris: Okay good.

Sarah Sampsel: Okay. So we are now into notes and I think we've already talked about note number eight that there are some other data sources that might be relevant for population health measures and, you know, I think we've already indicated it needs to be worked on.

Female: Yes okay.

Sarah Sampsel: Any...

(Crosstalk)

Sarah Sampsel: ...in the notes.

Helen Burstin: Paul was just saying something about Peter ((inaudible)).

Paul Jarris: Yes and (Peter Briss) or somebody working on the community guide could probably help us with other data sources and...

Helen Burstin: Okay. I'll talk to Peter. Actually I'll send him the whole thing to look at. There we go.

Sarah Sampsel: Okay. So let's move on to usability and I'm going to differ to Karen and Helen to make comments on usability since that's out in public comment right now.

Helen Burstin: Yes.

Karen Pace: Right. Usability has been a challenge. It's because we have more interest of course especially when measures come back for endorsement maintenance to see if they're actually being used as the true test of usability. And so we've had a taskforce working on this criterion and just posted their report for comment on Monday morning.

And basically the focus of the usability criterion as recommended by the taskforce is going to start with in terms of measures that haven't been used before kind of the hypothetical case for its

usability for performance improvement or some accountability application. And then moving into -- over time -- getting evidence that it is in use and is making - that there is some evidence that performance is improving or health is improving, etcetera.

So, you know, but the reality is right now and I guess for the measures that will be coming into this project, the criteria that you see in front of you will be operational in terms of looking at the measures that come in...

Helen Burstin: ((inaudible)) because the board should be approving the updated language December 1.
((inaudible)) might be able to...

Female: Oh, okay.

Helen Burstin: ...and we'll see if we can make that work.

Karen Pace: Well let me - so as a next step for this group for that would it make sense that kind of an assignment would be that everybody goes out and looks at that and kind of, you know, kind of feeds information whether it be to me or Elisa or whomever on, you know, what our thoughts are based on for what's out for public comment?

Female: Yes. And actually you can comment on it for public comment. That would be useful too because there is a...

(Crosstalk)

Female: ...you can just go to the report and enter your comments. But certainly...

Helen Burstin: ((inaudible)). Ron ((inaudible))?

Kurt Stange: No, it's Kurt. It's also probably worth taking a minute to think of what might be unique to measuring population health and I think that the intended audiences are worth some thought.

So rather than consumers, we might think community members and we might want to think community and multi-stakeholder group leaders in addition to policy makers. So just broaden the sense of audience from the kind of the provider/consumer audience.

Sarah Sampsel: Okay. Any other comments there? Okay. So on feasibility which is the next section, there have been - this is where it looks like Helen's really put some more information in about required data elements with personal health records, health information exchanges, population databases, etcetera. Anything as well as to taking out patients so it just says confidentiality is a particular concern with measures based on survey and for small populations. Any other concerns with feasibility?

Helen Burstin: And I'll check with (Peter Briss) on this section as well.

Female: Under 4A because it says for clinical measures, I just wonder if there's other things - I mean that's the one where we may need to expand a little bit.

Female: I just said it was not applicable. You want to even keep it there?

Paul Jarris: I mean there certainly are routine data elements generated in population health, (like) just reportable diseases, immunization rates. I mean you could even consider the YRBS or the DRFSS as a routine generation of data.

Helen Burstin: Okay. We'll think about that one. Okay. ((inaudible)). We'll take a look at that.

Sarah Sampsel: Since we only have three minutes I guess I, you know, does it make sense - does anybody else have other concerns or, you know, if anybody just wants to submit via email and we could say that we made it through?

Helen Burstin: In the comparison, you know, the ((inaudible)) issue obviously please take a look at that language. That's where I think this whole issue of harmonized, competing, and complementary - we probably need a little more thought on that so if you want to write some comments on that that'll be useful.

Sarah Sampsel: And I mean, I would be willing if folks want to send, you know, any additional comments to me. If you want to send them to me, I'll be glad to pull them altogether and get them back to Elisa and Karen and Helen.

Helen Burstin: Okay. Sounds great. Thank you.

Sarah Sampsel: So Elisa, I think it's back to you and I'm giving you two minutes.

Elisa Munthali: Thank you very, very much. This is the perfect time for us to go over our next step.

As you know tomorrow we're going to meet as a full committee and the workgroup that met yesterday on the framework will report out to everyone and many people that attended that group are also attending today's. So that will be good.

And then also this group will report out and then we'll continue our discussions as a full committee. And as we mentioned earlier, we will probably follow up with any additional thoughts that you have ((inaudible)) on our online forum which is CE now going back and forth with the group.

And then we as staff will start drafting the ((inaudible)) measures and we will circulate that to the committee for input. And it'll be the full committee for input. So we haven't determined the dates yet, but we should have dates from that hopefully in the next couple of weeks.

Karen Pace: So I don't know if this would be helpful or not and I'm just going to suggest it and if I'm turned down that's fine. I just wonder if that once we have this next draft of evaluation criteria it would make sense to have another call of this work group to then kind of use it to go through, you know, one of the population health measures to see if things work and if we've identified everything.

Elisa Munthali: Yes I mean, I think that's a good idea depending on everyone's time. We can definitely schedule that. I think it would be good to put it into practice for everyone. So we'd be happy to schedule that.

Sarah Sampsel: I mean I guess I think that's up to the workgroup too if they would find that useful or not.

Helen Burstin: ((inaudible)) email.

Elisa Munthali: Yes, we can follow up. Yes absolutely. So we can send out similar to what we did for these workgroups we can send out a survey and see if folks would be interested and then we can have some dates out there. We'll coordinate with you Sarah to see your availability and Paul and also Kurt.

Kurt Stange: Do we need to open for public comment?

Elisa Munthali: We should. And operator - I think (Tom)?

Operator: Yes, ma'am?

Female: I don't know if anyone on the public line has a comment they'd like to make at this time.

Operator: All right. Let me open up their lines. And all their lines are now open at this point.

Elisa Munthali: Any comments?

Peggy Honore: Hello?

Female: Yes.

Peggy Honore: This is Peggy Honore with HHS.

Elisa Munthali: Hi, Peggy.

Peggy Honore: Good morning to everyone. I'll be very brief with this. I most definitely concur with the members of the sub committee working group this morning who noted the HHS quality AIMS as being appropriately listed in Section 1C, especially as it relates to outcome process and structure. We did categorize the nine AIMS by those three categories and I'll be happy to provide that to the committee if it will reinforce those suggestions.

Elisa Munthali: Great. Thank you, Peggy. Appreciate it. Great. Okay any other comments? All right. It doesn't look like we have other comments. But I just wanted to thank everyone again for joining us yesterday and tomorrow and for all of your hard work. We really appreciate it and we'll be talking to you tomorrow. Okay. Thanks everybody.

END