

## **NATIONAL QUALITY FORUM**

**Moderator: Elisa Munthali**  
**October 6, 2011**  
**2:30 pm CT**

Operator: Welcome to the conference. Please note, today's conference is being recorded and please stand by.

Elisa Munthali: Good afternoon and welcome to the Population House Steering Committee's conference call. My name is Elisa Munthali and I'm with the National Quality Forum. Joining me on the phone from NQF are my colleagues Janet Corrigan, Kristin Chandler, Helen Burstin, Reva Winkler and Robyn Nishimi.

And before I turn it over to Kurt, perhaps I can turn it over to Janet if you have a few words before we start?

Janet Corrigan: Sure. Just to welcome everybody, this is a real exciting project for NQF. I know you've been making some good - progress already. And I look forward to kind of hearing about where you're at. As you know, this is a really somewhat new area for us.

We have endorsed some population health measures but this is the first really major project that we've undertaken to really think through with such a high powered group of experts where there are important measures that really would warrant going through the NQF endorsement process.

Thank you very much for all your time you're putting into this. I look forward to the fall.

Elisa Munthali: Thank you Janet. So Kurt I don't know if you'd like to give a few words of introduction and welcome.

Kurt Stange: Sure. I'll just (preview) the agenda that you've nicely put together for us. We've - as you'll recall after our meeting in person we broke into two groups. Those groups actually have met by phone.

And so the agenda for today is to hear from those two groups just to kind of bring those two ways of looking at things together, both the framework for how we conceptualize population health and then the group that really started to work on how we think about the measurement process for that.

Then we're - we'll have a period of public comment and then Helen Burstin and Elisa will go over with us the end game here. Well not the end game but at least the intermediate game of what a call from measures looks like so we can start to think about that.

And that needs to be - we need to get started writing that fairly soon. One of the things we've been struggling with here is defining the scope of the work and then getting the background materials in front of people before the meeting so we had some fodder to work with.

The group that - Sarah did a wonderful job leading yesterday - head of - had a very nice job that the NQF staff did, particularly Helen I think, in looking at some of the criteria for doing population measures and extrapolating that from some of the existing NQF measures and so will tell us about that.

The group that we had that was developing the framework, we spent a lot of our time talking a little bit about the scope of work.

And Elisa's done a lot of work in pulling together more than I frankly had time - a chance to read in detail but it pulled together a lot of background materials for that group to really use as fodder for thinking about a framework.

So Matt will have a little bit of more of a challenging time summarizing that group's work. And Matt if you want to talk a little bit about what's happened in the past but also think about what that group might do further, particularly using some of those background materials that would be fine.

So I'm going to stop talking in a minute here and we'll have - we'll go to a synopsis of the framework workgroup's discussion and then a synopsis of the measurement ((inaudible)) workgroups discussion. Any comments before we proceed with the agenda? Okay. Can I turn it over to you Matt?

Matt Stiefel: Yeah, sure. This is Matt Stiefel. So I didn't know I'd be providing this synopsis so - and it's a synopsis of a pretty wide ranging discussion so I'll do my best but others feel free to jump in as well including topics as broad as, you know, what is population health, you know.

What is a community and what's the framework and what - and especially the scope of the work of this group.

And I think that was the central topic and especially around the distinction between outcomes and determinants and how far upstream you go with determinants in coming up with a measurement framework for population health.

We got also a report from (Don Jacobsen) from LA County about the work that they are doing in support of this group. So maybe I can spend a few minutes summarizing my understanding of that as well. And so let's see, starting with that framework - well and I'll also mention some comments.

I think Larry Cohen also started with a comment about scope and some concern about if the scope remains narrowly defined with behaviors in preventive services those behaviors obviously occur in a context and especially environmental and community factors context which he thought is important to include in the frame.

And so there was a fair amount of discussion about that both environmental and social determinants as part of the frame as well. So in Dawn's description she talked about I think four elements of the background document.

One is just providing a set of definitions of population health and related concepts as well as these conceptual frameworks and ask group because they're doing a scan of sentinel documents around frameworks for population health and asked the group to send to them any document that they know of to help their work.

She mentioned, and it will likely as we heard in the first meeting, a framework developed by the San Diego Department of Health and Human Services that they'll be using. So we'll expect to see that they'll rely heavily on that framework.

A third task that they're doing is pulling summarizing measures which is - it's kind of at the crux of this work. And again, looking at frameworks for those measures like the county health rankings, the healthy people measures, Trust for America's Health Commonwealth Fund sources measures.

And I'm sure among those there are thousands of measures which then led to the topic about, you know, how do you - what's an appropriate framework in which to put in - sort and frame those measures. And so those are the main activities of the LA County group in support of our work.

And we talked a little bit again about the frame there about the - beyond the narrow definition of behaviors and preventive services.

By the way, I think the part that - there was some discussion about (Rand) work in - that (Paul) brought up that he thought that (Rand) had been, you know, hired to do some work in support of NQF population health measurement.

I actually participated in that work. I'm not sure where I was during that part of the conversation. It was actually in support of ARC and CMS. And they did a scan and then a prior - pulled together an expert committee to review this list of hundreds of measures that they had gathered.

And so I think NQF staff you've been looking for that and I can help track down the work with (Rand) on that.

Female: Thank you.

Matt Stiefel: And so Mike sort of talked about, you know, the - we got into the framework discussion thinking of a structure process outcome kind of frame for the measurement work.

That then led to a pretty lengthy discussion about determinants versus outcomes and the extent to which this group is looking at - primarily at measures of health outcomes or the broader context of determinants.

And the whole causal pathway of determinants, of behaviors but behaviors influenced by physical and social environmental framework in incumbent education and those kinds of things. And I don't think we landed on anything.

Except I think a general consensus of keeping the frame broad and not limited narrowly to behaviors and preventive services. I think that maybe all I would want to say about - in summary of the discussion but others please feel free to jump in about any of that conversation, especially about the framing.

Kurt Stange: Matt I think you're a great sausage maker. I mean you really pulled it together in a nice casing and added some nice coherence to that.

I think what - this is Kurt, I'll just add one thing. I think that what we're doing is - the committee has been helping with this environmental scan and pulling together where we might find sources of both frameworks and others that have done work on thinking about how to do population measures so we don't have to reinvent the wheel.

And I think we're getting a good amount of materials here that the committee might want to reflect on. Matt or others do you have a sense for what this subcommittee or working group would do next?

Is it to look over the materials that we have and to think about a frame into which population health measurement can be put even if the scope ends up being a little narrow within the large frame, somebody that contextualizes it? Is that the next task or is it something else that's the next task here?

Matt Stiefel: Yeah, that's what I see and I actually think that that work will begin in the latter part of the agenda in this meeting. Is to begin to look at the frameworks. But I just think yes, so the short answer is yes, is to evaluate the frameworks and to see what makes sense.

And that fundamental question is the elephant in the room about I think the - how far upstream you go in determinants of health versus outcomes. So the framework can be agnostic to that and just provide a framework.

But I think that the whole - the committee as a whole should concurrently be wrestling with that issue because it's a pretty fundamental and deterministic set of assumptions on which our work will be built.

Kurt Stange: Other comments? Is Bobby Pestronk on the line?

Female: Kelcey?

Operator: He is not on the line.

Female: Okay.

Kurt Stange: Okay, because he had done a - kind of a half a page summary actually before this workgroup's call and then did a revision of it afterwards that was trying to pull things together. So since he's not on I won't try to represent that. But that would be something that we would - just might want to consider.

Female: And Kurt he is expected to join us. I think he might be tied up. So perhaps we can go on with the discussion and talk about the framework.

Kurt Stange: Okay. Do you want to - so do you think we should talk about the framework now or should we let Sarah present and then come back to that?

Helen Burstin: This is Helen. Kurt, I think it would actually be good to kind of keep all of this together since I think it's - framework and scope are all kind of related with the definition. So maybe we can do framework and then come back to definitions when Bobby's on.

Kurt Stange: Okay. So Matt framed the elephant in the room as thinking about how far upstream to go in what we call population health. If I understand your framing Bobby, so there's a health of a group of people geographically or otherwise defined.

And then there are the kind of social environmental healthcare and other determinants of that and behavioral - and other determinants of that. And so part of the reason we're having a framework I think is that we can know exactly what we're talking about here.

Mike Stoto: Hi everyone, this is Mike Stoto. I'm just joining now as I was in class until a minute ago. I think that the - one way to think about the question about how far upstream do we go is to think through this point I've made a couple of times about responsibility versus accountability.

And I think that, you know, when we are focusing - when we develop performance measures for healthcare organizations like most of NQF work, we really are thinking about what a particular healthcare unit does and holding it accountable.

And that's implicit in that. We don't always think of that. I think when we think about population health it's the healthcare system that could do something, it's health departments that could do something.



It's other things like schools and parks departments and nonprofit organizations that can do other things.

And I think that in terms of performance measures we really - and for population health we really need to think about what measures that relate to what these different organizations do to get at the ultimate goal of population health.

Kurt Stange: Yeah. I think one of the ((inaudible)) that we did make on our first day together was the idea that we can go beyond thinking about the audiences as just being existing organizations and we can't think about multi stakeholder groups which does broaden the spectrum of possible interventions.

Mike Stoto: And we also identified this problem of shared responsibility and the difficulty of managing a shared responsibility.

And this point I was making really relates to rather than trying to develop measures of the outcomes that have shared inputs, we really need to focus on the activities, measures of the activities that could lead to the outcomes is our ((inaudible)) as we want.

Kurt Stange: Matt would you like to go over your pictorial - your one page pictorial diagram that's at least one initial frame for thinking about this? And Elisa I'm afraid I got my large packet out of order and I don't know which page this was in the packet.

Elisa Munthali: This is page 3.

Kurt Stange: Okay.

Matt Stiefel: Okay. Sure Kurt I'd be happy to. And let me just also note that I think as I mentioned in our in person meeting this isn't - I wouldn't consider this novel. There are hundreds of such frameworks of the relationship between the determinants and outcomes of population health.

And this is just one particular way of assembling them that may be useful for our task and - or we may decide that there's a better pictorial way to describe it. I think it is - it can be useful in addressing this very question that's on the table, about the distinction between determinants and outcomes.

And again in a kind of logical model framework, pictorial framework, it at least describes some of the important causal pathways. So that is kind of an overview. At the left of the frameworks are the upstream determinants and factors that influence population health.

And, you know, I think as Larry and others noted it's kind of cheating a little bit to have this little box called socioeconomic factors which probably is the most powerful set of determinants of all of the health of a population.

It is - peeling through that box are probably, you know, scores of important determinants that may be glossed over a little bit by having just a little box called socioeconomic factors.

But broadly there's genetic endowment of individuals and people in the population, socioeconomic factors including important ones like incumbent education, the physical environment and things like clean air and water in parks and public safety and those kinds of factors.

And then the first potential contribution of the healthcare delivery system prevention and health promotion and we spent a lot of time in our first meeting talking about preventive health services measures.

But in the context of this framework we just need to be reminded that those are not measures of population health they are measures of upstream determinants of health.

In the next category are individual risk factors and I think it's important to name those and call them out separately from measures of health because I think historically in healthcare we have used those as surrogate measures of population health because we can measure them.

Especially the physiologic risk factors, you know, BMI and hemoglobin A1C and blood pressure and metrics like that that we can do in the healthcare system that our "objective" don't rely on asking people how they're doing.

But again in this framework they are still not directly measures of health but risk factors for health as well as the behavioral risk factors in fact - and that's probably the other box in the initial framing of this work.

So it's that box of behavioral risk factors - smoking, eating, drinking and exercise kinds of factors which we know are fundamentally important determinants maybe accounting for 40% of premature mortality.

It's kind of that box and the first green box were the two initial categories in the framing of our work. This idea of resilience is I think not well understood but of growing notice and importance in terms of impact on downstream outcomes including life expectancy and incidents of chronic illness.

And we're just learning about how those or that - how that notion of resilience is influenced by behaviors, physiology and socioeconomic factors as well. Those risk factors in turn influence but aren't the same as disease and injury.

Again the - in a kind of narrower definition of health and by the way this is probably the transition point between the set of determinants of health and measures of health. So to the right of this are more of the measures of health outcomes.

Disease and injury I think so is a narrow definition and I think in that movement of moving toward health related quality of life I'd point out that disease and injury are defined only in the negative and don't really address important aspects, positive aspects of health.

And then the second potential contribution of the healthcare delivery system, medical care and treatment and response to disease and injury is shown here that could have positive and negative effects on disease and injury including unintended outcomes of medical care.

And mitigating the relationship between disease and injury and states of health, health and function and death. And I think it's important to make that distinction in a framework like this because two people with the same disease status may have very different self perceived health and functional status.

So those aren't measuring the same thing. And I think if you ask people what's more important to them they would - I think they would answer that their functional status is ultimately what's important.

And then right of that and I think as I mentioned earlier, there was especially in the '90s this movement to define health more in a positive sense going back to the WHO definition and the idea of health related quality of life.

And the same notion that it's a different construct than functional status of self perceived health. Two people with the same level of functioning may have very different perceptions of their well

being and quality of life. Interestingly, the military health system has - they've adopted IHI's triple aim.

They actually have a fourth aim of readiness. And believe that this idea of well being is fundamentally important to the readiness of the US Armed Forces.

And so they are embarking on a major initiative for measuring and improving well being and that health related quality of life both in the military health system.

And then of course all of the feedback - I don't think we have time or need to go into that piece - broad upstream determinants' influence, well being of individuals in the population as well as having a feedback effect as well.

This little arrow on the left is probably also given inadequate attention in this framework.

Disparities in the Kindig definition of population health, he describes it as the health of individuals in a community or geographic area and the distribution of that health among those individuals.

And that's what's meant by the disparities arrow. And just the point that any of these boxes, any of these determinants and outcomes can be measured in terms of disparities from the upstream environmental factors all the way to well being.

And I think that's an important and an overlay on this and perhaps is given inadequate sort of visual emphasis here. And I think Larry was suggesting maybe have a broad arrow on top of the framework that showed the importance of measuring the disparities in any of these areas.

The last thing I'd say about this is that it does illustrate that debate or discussion about the distinction between determinants and outcomes. And the challenge with the measurement of determinants is that there's a long tail - upstream tail for determinants.

And if we get into the measurement of determinants where do we draw the line? And in so what frame - what overlaying framework do we use to describe that. In one narrow sense starting with - this is kind of - I'll interject an opinion here.

Starting with measures of health outcomes, clarifying measures of health outcomes that move kind of right here, measures of mortality in a population and some measures of function and self perceived health I think would be a great start for this work.

Too I think those measures have been largely missing from the healthcare delivery system. And instead as I mentioned, we tend to measure the disease and injury or the physiological risk factors.

I think it would be a great start because then that would cause organizations and communities to rethink the relative importance and contribution of medical care to those ends and the necessity to work in broader multi stakeholder coalitions in communities to - because of the important influence of other upstream determinants and factors on those health outcomes.

So I think I'll stop there unless anybody has any questions about this framework.

Kurt Stange: Well I think that's very helpful and I don't think for the large group we want to talk about the details of this. But what it does bring to the fore is the idea that on the left you have these biological, social, environmental, behavioral, maybe even healthcare determinants.

And on the right you have measures of health of the population that's function or well being or readiness or you could even add social role function and of course being alive. You have those kinds of outcomes.

And do people have - does anyone from the large group want to effect a charge to this group to develop a model, something like this, that would be with an eye toward being something that would be simple and it could be used to guide a call for measures and could be used to put into context the different things that might be measured?

Mary Pittman: This is Mary Pittman. I was not on the subcommittee call but I had a couple of questions whether it came up and related to the difference between equity. And there's a lot of focus particularly in public health conversations around equity versus disparity.

They both have a role but there's a difference between disparities where there are differences in equities that probably have more of a fairness ((inaudible)) brain to it.

And also I agree that the socioeconomic factors probably need some further unbundling and some relationship to the health component as well as the disease intermediate outcomes. I just...

Kurt Stange: Mary do you have any suggestions for the committee as they look at this and how they handle the equity versus disparity and how they might think about incorporating that into the model or into a framework?

Mary Pittman: Yeah. I think there have been and I will go through my files, I think there have been, you know, it may bring up some different frameworks. There are some frameworks specifically around equity and economic equity in particular and health and I can share that.

I know Larry probably has a fair amount of the same literature but I'd be happy to forward that. And I think it needs to be built into the model.

Kurt Stange: Okay.

Matt Stiefel I think those are great points.

Kurt Stange: Anyone else want to get anything on the table for - as part of the charge or as part of environmental scan ((inaudible)) to include in - as this group then looks that over and tries to come up with a framework to come back to us?

Helen Burstin: Kurt this is Helen. I know Dawn is on the phone as well, who's been working on the...

Kurt Stange: Yes.

Helen Burstin: ...environmental scan and the framework. And I wonder if she just wants to add anything. I know she's been exploring these verdict model and I think she can work with this committee to help think some of those issues through.

Kurt Stange: Yes.

Helen Burstin: Dawn, are you with us?

Dawn Jacobson: I am. Hello everyone. Yeah, I think that the Matt - or the framework that Matt walked us through and sort of looking at some of the new - what, you know, the alternate frameworks that would have health equity front and center, you know, would be great to look at integrating that.

Also one thing I'm thinking about already, just I think you guys know this about our approach and sort of what we're doing with the scan, is we automatically go and are aware of the activities, strategies sort of that would be - had clear ownership.



And I'd almost want to add a line that would include activities but there's probably, you know, a variety of frameworks that will get integrated at some point either in, you know, covered by you all and we're happy to, you know, find documents and add them into our report.

Kurt Stange: Right. So Dawn...

Madeline Naegle: Hi. It's Madeline, Kurt. I had just one comment that I wanted to follow up on what Matt had said about the notion of well being. In our face to face we talked a lot about the fact that thinking about these measures brings up more potential for consumer response and input.

And Matt Used the term perception of well being which is being used quite a lot in some of the work we're doing about self evaluation of health status.

And I'm wondering if you want to consider that so that it's not only what an external agent is measuring about well being or what we think well being is but the self report of well being or perceived well being.

Matt Stiefel: That's a great point.

Bobby Pestronk: Kurt, this is Bobby. Sorry to miss my moment. I had two suggestions on the diagram and some for Matt. One is a box of equity actually could be placed on the far left of the diagram even preceding genetic endowment prevention, physical environment and socioeconomic factors.

Contributing directly and through the rest of the boxes to well being. And I think that that would put front and center what the thinking about equity is that it is - it's filtered through the rest of these boxes for sure. But it has a direct impact on well being even unfiltered.

And so the efforts to address equity can in fact on its own as well as through these other filters, lead to well being.

And then the second suggestion about the diagram is to have the arrow from well being that's going back right now to socioeconomic factors perhaps go back to that whole box, the bigger box in which the four smaller boxes are because well being has a direct influence on all of those, not just socioeconomic factors.

And then if we added equity on the far left then you could have a well being line going back to equity as well which again suggests that equity itself results in well being and well being is likely to result in equity as well.

And that's basically what I think people are trying to have more - have other people understand that direct ((inaudible)).

Matt Stiefel: Okay, great point.

Kurt Stange: So could I ask anyone who has anything else that they want to put into this consideration of framework, to send that to Elisa as soon as possible?

And then Elisa, you posted a lot of information for us already, Dawn as well, whatever you have that you'd like to, even in an early stage have this workgroup consider. And then maybe as a next step to set up another call after that - people have had a time to digest that.

And anything you'd like to do to kind of frame our looking at that match or consolidate it in any way would be great.

Elisa Munthali: Okay. I can do that.

Matt Stiefel: And the framework workgroup can take those and work with them. That'd be great. Hey, just one quick follow up on Dawn's point about activities and strategies and how that interrelates with this model.

I think Kindig's framework for the county health rankings had this other dimensions that I think he called policies and programs.

And that was the idea, is to kind of have this dynamic model that while of course medical care and preventive services have an influence, policies and programs broadly defined both from individual organizations and employers but also communities affect these dynamics and relationships.

And it - I think it's a good idea to somehow - maybe it's assumed but maybe it's useful also to show how that affects these dynamics and relationships. That's kind of what we're after.

Male: Actually one thing I think would be good, actually thinking about this, where medical care is in the model looks doesn't to me kind of fit quite as well but it seems like medical care is the obviously healthcare system equivalent.

And the policies and programs is more of a public health or government agency kind of equivalent to that. So thinking about how interventions are part of these determinants of population health and how to fit those into a model would be something to do.

And you might want to do something creatively about not having them part of this - not intended linear process but something that people read as linear going from left to right, maybe have them above and below intersecting with that.

Dawn Jacobson: And this is Dawn. This is where on the first call (Jackie Merrill) brought up systems dynamics models. It gets more into a feedback loop way of depicting things and they want to consider that.

And then also they have the people 2020 depiction, what ((inaudible)) ecologic model and sort of, you know, sets apart quality of life, health determinants within activities. I mean there are just ways that we can look at different documents and see what works best for this committee.

Kurt Stange: One thing to do I think would be to try to keep something - try to make this as simple as possible. Well including all of these great ideas people have had.

Matt Stiefel: Yeah.

Kurt Stange: Good luck with that Matt.

Matt Stiefel: Well this is a - I guess just a question - a process question so we have this great work in support of the group by Dawn and her team and a framework workgroup. How do we integrate those two?

Helen Burstin: Yes, this is Helen. Matt this is Helen. I think actually it would be very useful to have you kind of be the group who works closely with Dawn as she's developing this work. She just offered for example, to share source documents with you.

It would be very nice to make sure that the work that will emerge out of the commission paper is aligned with the thinking of the committee which is why we wanted to kind of keep this workgroup going. So almost her thought group to go to, to kind of think of these issues.

And again she may be able to do some of the actual development work since it's part of their scope anyway.

Kurt Stange: Yeah.

Female: So who would we send our comments and suggestions to? Is it to Dawn or is it to Elisa?

Helen Burstin: Just send it to Elisa and...

Elisa Munthali: Yeah.

Helen Burstin: ...Elisa will coordinate it all.

Female: Okay, thank you.

Male: And Matt also I think that Dawn has very kindly agreed to share works in process, quick and dirty environmental scans and things with the group even as she works on a different timeframe to get her report out.

But since the timeframe for the call for measures is before she has her final report done I think thinking of her also - her and the LA County folks as a resource for this group to get at least something that will be good enough to help inform a call for measures even while she's doing the, you know, the more scholarly and longer term work.

So think of her and her group as a resource for getting somebody that's good enough to help the - help inform the call for measures, to help frame the call for measures.

Mary Pittman: This is Mary Pittman again. There's one thing that still bothers me about the framework and the way it is and I was trying to think how do you keep it simple.

But in the individual risk factors in addition to behavioral, physiologic and resilience I think we have to have a fourth box that is environmental risk factors.

It allows us to take that socioeconomic determinant in the physical environment and have it displayed over as also individual risk factors that, you know, if someone happens to live in a toxic environment it's going to have an impact on their well being and disease and injury.

And it doesn't carry through the model enough for me just having it in the first determinant box.

Matt Stiefel: Okay.

(Crosstalk)

Matt Stiefel: Helen just one other thought is that just - I think that the other workgroup on measures might have the same or similar relationship with Dawn's group as well because my understanding is that they're also collecting measures as part of the background work.

So it seems like both of our groups need to have this connection...

Helen Burstin: I think you're absolutely...

Matt Stiefel: ...to the...

Helen Burstin: ...right Matt. Yeah, I think you are seeing the more approximate but I think you're absolutely right. And in fact I think a lot of the work Dawn's doing on the environmental scan will be really informative as we craft the call for measures actually.

Kurt Stange: Beautiful. Well thanks everyone for help with (concomitant). Matt thanks for your willingness to be drafted for this to begin with and to step in here at - on short notice for this call.

Matt Stiefel: Sure.

Kurt Stange: Why don't we turn it over to Sarah to tell us about the...

Female: Actually Kurt, I think...

Kurt Stange: ...report you did yesterday.

Female: Kurt, I think Bobby's on the call.

Kurt Stange: Okay.

Female: Do you want to go back and do definitions real quickly?

Kurt Stange: Sure. Bobby, do you want to go back and tell us about the helpful definitions you came up with both before and after the - this first workgroup's meeting on Monday?

Bobby Pestronk: Yeah, sure Kurt and I apologize for joining late. And thank you for including us on the agenda. These were two definitions that I sent in after the last call that we had.

The first one which was point three was basically cobbling together parts of the definitions that we were - that the staff supplied us with before the call.

And then as the call proceeded I was making adjustments to that - to point three trying to accommodate this in my own head and then subsequently to the benefit of others, the discussion that was taking place.

And so the population point four represents what I thought was a mix/match reorder and add to the materials that we have been given based on conversation that took place. In part this is making use of elements of the language that Kindig and that (Dawn Hayes) provided.

I added some of my own language to it and then I reordered some of the material that (Dawn Hayes) had in the (Dawn Hayes) definition.

And then added - in trying to think about this and this is actually part of the conversation as well, what was it that NQF could send out in its call for potential measures?

I added the last paragraph and my thinking there was that what NQF might request because of the emphasis on our first call on disparity and on equity was not just a call for a measure but the call for anyone who wanted to submit a measure, a pair of measures which would force the delivery of measures that would point out the disparities that exist or the inequity that exists.

And so frame in the use of best and worst outcomes and using as examples two that came up in the last call which were obesity and tobacco use. Anyone proposing measures would propose kind of what the best state would be or what that - the best measure would be.

And also propose what the worst outcome was and these all in relation to the environmental, social and economic determinants that were discussed on the last call as influencing those



outcomes. The change would obviously be in the reduction of pairs of measures rather than single measures.

But it would force those who are going to be use - ultimately using NQF supplied measures to use pairs of measures which would force the contrast between health outcomes - best health outcomes or good health outcomes and worst health outcomes.

I don't know that I have much more to say about it. I did give some consideration since point four was produced in thinking about some of the recent publication on priority areas for improvement of quality and public health by the Assistant Secretary for Health's office and the characterization of qualities, characteristics of population health that might be woven in here.

But I hadn't quite figured out how or whether that would be helpful or not. As we talked on the last call and as I listened to this call as well, I think what we're after is simplicity and I don't know whether adding any of those characteristics of quality would actually be useful.

The other idea that I have had and I know that several folks have talked with me about it, is that rather than - I'm not sure there is a grand lightning bolt that's going to strike and give us the best definition of population health.

Lots of people have tried to do that and this effort to cobble together in a meaningful and logical way if in fact that's what I've done here, definitions that others have already provided, seems to me to be the best approach. So Kurt that's all I've got on this.

Kurt Stange: Well that's very helpful. And I think the way you've done this shows that we don't want these two groups to get (re-aside) and (off aside) separately that they need to inform each other.

And the approach that I think actually both of them that are taking is to try to take what's out there and pull together things in a pragmatic way that will help inform a call for measures.

And while we don't want to make it too complex I think if there are things out there like the priority use from ((inaudible)) and public health, things like that, that we should consider it.

I think that it would be helpful to say that was - be able to say that was part of our process that was considered somehow so people get a sense we're not reinventing the wheel.

And that will I think give the call for measures more a credibility particularly with the organizations that might be actually responding to the call if there's a sense that their work has been somehow considered in our process.

Matt Stiefel: It's Matt. Could I ask a question Bobby? There's a lot in here and I like it a lot. It's just one question - I'm not sure I completely get what you mean about pairs of measures.

If you're just talking about a measure including the measure of equity or disparity for that measure or if you're thinking of something else with a pair measures.

Bobby Pestronk: At the time I constructed it I was thinking that I wasn't quite sure how we were going to - what the measures might look like.

And the discussion led me to believe that - and this is just my own way of thinking about it - led me to believe that if we were forced to recognize in the measures that NQF ultimately recommended, that in fact there were these disparities in the choice of measures that anyone who was using the measures would be making.

We would be forcing people to confront the fact that these differences exist. And encouraging people to think about - encouraging people who would use the measures to think about what differences do exist along whatever health outcome dimension they thought to choose in the specific political or contiguous geographic area that they were going to focus on.

Now it may be that the way that NQ - it may be that the way that measures for the indicator language is constructed makes those differences in outcomes between subgroups in that population clear but I was looking to try and force that to happen.

Kurt Stange: Great. So you're going to stick on this first working group Bobby?

Bobby Pestronk: I'd be happy to. Sure.

Kurt Stange: Okay, great. Okay...

Matt Stiefel: Just can I ask one other thing? I know this is a long agenda today but speaking of harmonization with other major efforts is it worth a nod to healthy people 2020 here in this top level framework about how they're framing population health or maybe that's already embedded?

Bobby Pestronk: I could - I don't - again I'm not sure of what our process is. I'd be happy to look at what healthy people 2020 is suggesting in the area of population health and see what that language is and see whether I can cut and paste something that would make sense so that we - if this ultimately or something like it were ultimately adopted we could give a nod to 2020 and perhaps also give a nod - it would be the same thing with the after.

Not the after but the (ash)...

Female: Right.

Bobby Pestronk: ...characteristic as well if you thought that would be helpful.

Female: I think that would be very helpful. Yep.

Kurt Stange: Wonderful. Great, well if I could ask anybody who has anything else that they want to put on the table for this group to consider to please try to get that to Elisa this week if possible so that Elisa if you could get that together and then work with Matt to schedule a time where this group would have a time to pour over what's now getting to be a lot of materials and then get a time to work on that, that would be great.

Elisa Munthali: Okay. I'll do that.

Bobby Pestronk: And Kurt, it's Bobby, quickly could I ask the NQF staff actually to do that look in 2020 and just email me whatever language they find?

Elisa Munthali: We'll do that.

Female: Yep. And we'll also...

Bobby Pestronk: Okay.

Female: ...pull the HHS quality and public health characteristics as well.

Bobby Pestronk: Thanks a lot.

Kurt Stange: Great.

Female: Sure.

Kurt Stange: Okay. Sarah, your group did some really good work yesterday on the measure evaluation criteria based on the changes to the inquiry that folks had made since our first meeting. Can you update us on that?

(Sarah): Sure. So first of all I'd like to thank everyone who joined us yesterday and provided their feedback. We can report success in that we made it all the way through our evaluation criteria at least once with a first look and, you know, good discussion.

And, you know, thanks to Helen and Elisa and others at NQF who had really done the first draft after our in person steering committee meeting. And I'm not going to, you know, kind of note every single thing that we changed.

In the document that was sent out you'll see red text on the right hand side which is indicative of an area where we made suggestions. You know, I will note that there are some areas where I think we all agreed that were, you know, there may be some - other options for wording.

And so we're open to any suggestions for those and we just ask that you forward them.

And, you know, one of the things that we talked quite a bit about and we also had the benefit of ((inaudible)) on the phone during our discussion is, you know, again ensuring that once the population health is by definition has been agreed upon that, you know, we would need to go back through and ensure there's alignment with the criteria, with that definition.

And that everything that we've recommended makes sense. And then, you know, we talked a little bit about this concept about, you know, the wording of provider and shared accountability and how does that differ with population health or public health.

And again, you know, as Matt suggested, the evaluation group needs to be working closely with Dawn and the UCLA group to come up with what makes most sense.

And I know Dawn, you know, has, you know, spoke up a number of times on the call to indicate, you know, that they're thinking about that, they're open and receptive to our suggestions.

Because, you know, I think we all agree that when we say something like provider it again takes us back to that clinical arena. And we can't exclude providers from population health measures but they do need to be broader. So that's one thing, you know, that we still need to tackle.

You know, I would say kind of, you know, the other piece that we were discussing is the concept around - or some of the issues around how documentation of evidence and how that might differ for these population health measures.

And one of the recommendations was that we look at and have some alignment with the DHHS consensus statement on quality and public health. So that's work that still needs to be done but how can we align since Health and Human Services has already thought about that considerably?

You know, as the slide shows that's up, you know, we talked about all of these areas and again our suggestions are reflected in the PDF document that was sent out with the full committee or the full workgroup recommendations.

I think overall, you know, at this point we don't feel that there are major significant changes to the criteria as they stand. There are some enhancements and perhaps augmentations that need to be made so that the criteria are translatable to public health.

Some of that information and augmentation needs to happen in some of the notes through the document which are, you know, more of the typical, clinical ((inaudible)) type, you know, other health plan or organizational CMS type measures that may not translate as well to public health.

But that's just something that still needs to be worked on. And then, you know, the other area that I think we really talked about was data sources and, you know, probably needing to look a little bit more at things like, you know, analogous to an EHR might be a state registry and so what is that language there?

You know, do we recommend using HLA 7 language or how do we, you know, ensure some consistency there? So I think overall we made it through the evaluation criteria. We are open and receptive to additional feedback and there's still, you know, we do know there's still work to be done.

And some of it needs to be in tandem with the - well I'm just going to call it Matt's workgroup. With the framework and scope workgroup but also, you know, with the work being done by Dawn and others. So, you know, I think there's more to come.

And then, you know, one of the things that I think we will need to consider as a steering committee and, you know, we can start as the workgroup, is taking our current recommendations and kind of running through a test to measure to see if what we've recommended works or if additional tweaks need to be made.

Kurt Stange: Wonderful. So that really is good work. And Sarah, it seems like - I think the point that Dawn and her group will be sharing some of their environmental scan about existing measures that might help inform your group's work.

And it also seems like you're working closely with the NQF staff on getting a draft of a call for measures.

And I'm just - I'm wondering should we discuss - I defer Sarah, to you and Helen and Elisa whether we should discuss your committee's work now or whether we should hear about the plans for the call for measures and discuss that all together.

(Sarah): I would need to defer to Elisa and Helen on that one.

Helen Burstin: Before we continue that we think we should probably open it up for member and public comment on the work that the workgroups have done.

Kurt Stange: Okay. And actually even before that, anyone on the call want to comment or have - ask Sarah's any questions?

Ron Bialek: Yes. This is Ron. Sarah, thanks so much for a great recap. And a question that I sort of have for the whole group is we - and as Sarah reflected, you know, there's a desire to integrate the quality improvement aims from HHS into this.

And a question that I would like for people to consider is, you know, where might be the most appropriate place for inclusion?

So for instance, under an evaluation criteria under impact opportunity and evidence would that be a place where somebody submitting a measure would say how it is they've considered the population centered, whether it's equitable, proactive, health promoting, etc.



They wouldn't necessarily need to be able to say it applies to each of these. But we'd want to know how it is they've considered these aims. Would that be an appropriate place or might there be other places appropriate for inclusion of those HHS (plans)?

Helen Burstin: I'll jump in Ron. This is Helen. It was a - it's an excellent question if we could weave it through the document, I at least made it fairly common by moving it under high impact. So the way we identify measures that are high impact would be they are part of a national quality strategy or NPP.

And I specifically added the note that for pop health measures high impact would also be identified by the national prevention strategy and the HHS consensus statement. If there are better ways to do that...

Ron Bialek: Great.

Helen Burstin: ...we'd be open to that as well.

Ron Bialek: I guess my question was really is it a note or is it something that we require people to address? And I think there is a big difference between the two.

Helen Burstin: Okay. What do people think?

Female: I think you might as well at least get the perspective of the person who is submitting, you know, a potential measure as they may have other sources that you're not familiar with. And so I think you at least could gather additional information by requiring that it be addressed.

(Sarah): Let's - this is Sarah. Let me change the question a little bit. And I'm asking this from being a former but not reformed measure developer.

In that when considering criteria as the steering committee, you know, there's a differentiation between the note and a differentiation between requiring people to address.

And if we're requiring people to address, you know, they obviously would need to answer as Ron, you know, kind of proposed or, you know, wanted folks to talk about. Each of those or, you know, which one of these or how many of these do they address?

And so as a steering committee would we use that data or would we use that information or wouldn't we? Because if it's just there then to me that's not a criteria.

So - and maybe that's something everybody needs to walk away from and just sit or, you know, and we can provide more information on it and how it might look in either way.

But, you know, I would just suggest as, you know, a steering committee and then as the evaluation workgroup we really need to think about how we would use that information and if we would use that information. You know, I think it's a great idea.

I just want to make sure that the information is actually useful if we're going to ask measure developers to go through the exercise.

Helen Burstin: And I'll just point out, this is Helen, that actually at our current submission form under that particular impact sub criterion you do need to indicate which priority area, which goal.

So in some ways we could spell that note out a bit more to make it clear that, you know, you'd actually need to tie it to one or more of the specific characteristics or the - or elements of the prevention strategy as well.

Ron Bialek: So if somebody submitted a measure and said it doesn't really apply to any of the aims we then would say it needs to?

Helen Burstin: Well I think that's a question for the committee although having - I just reviewed the consensus statement yesterday. And just given the breadth of those listings...

Ron Bialek: They should be able to.

Helen Burstin: ...((inaudible))...

Ron Bialek: Right.

Helen Burstin: ...and it's hard to imagine you couldn't fit something in there I guess.

Ron Bialek: Yeah. And I guess the way I was asking the question was I would like to see it be required that it address at least one of the aims and it be a - be something that is plausible the way it's presented.

Kurt Stange: Good. Good.

Matt Stiefel: It's Matt. And it raised an issue that I don't have an answer to but it just keeps coming up and this kind of elephant in the room about scope and how far upstream and the determinants we go affect also the criteria because it seems like the criteria need to somehow address the question of scope.

I think it's just this broader issue that affects both of our workgroups. And, you know, it's - I don't know if the right approach is to make a decision upfront or if the challenge to the workgroup is just to wrestle with this elephant for a while to come up with a conclusion.

But I mean for an example, high school graduation rates, unemployment rates, crime rates, fresh water, public parks, those are all potential measures and I just think we're going to need to think about how do we - what the framework or decision rules do we use to determine whether something's in or out of scope for this work.

Male: It seems to me that that's a helpful thing that the model should do. And if part of the audience are mostly stakeholder groups and we're really focusing on the right side of a model that really is focused on the health of a population geographically or otherwise, defined.

The model would say if you're really trying to affect that, look at all the things that affect that. What is the role of each participant in such a group in affecting those multiple determinants of health? Who's going to be both responsible and/or accountable for different aspects of that?

But a model that does at least include those things keeps us from just looking under the light post and it gets us working around in the dark where some of the potential solutions are I think.

Matt Stiefel: And - go ahead.

Female: Go ahead.

Matt Stiefel: Is that Bobby ready to say something?

Bobby Pestronk: Yeah, but go ahead Matt.

Matt Stiefel: Oh yeah, just a brief follow up. Another question is do we give in our criteria, priority to outcome measures or some distinction between outcome measures and determinant measures? And does that enter into our criteria?

Sorry, I don't have answers but those are just - it seems like they're questions that we need to address.

Helen Burstin: Yeah. Those are great questions Matt. This is Helen. And actually our evidence requirements make it clear that we do always have a preference for outcomes. So I don't know though.

And I think that's part of the idea here is we don't want to necessarily create a whole new document with a whole new set of criteria. What we're trying to do is make the criteria work for those in the population health space. So some of this is we already have a preference for outcomes.

We would need to put it in the context of over health (premise). I do think the bar to scope issue is one I suspect if we asked, you know, most of the folks who perhaps have been engaged in NQF for a long time they would probably say measures like education are - and income are probably too far out of scope.

And maybe those would be measures you would, you know, parts of a measure but probably not closely related enough. But I think those are really important issues we'd like to - that was part of the reason to make the scope committee - the scope framework committee to help us sort that through.

And my hope is that as that group perhaps does its next call we'll have them actually try to - we'll try to draft something. But I think in some ways it's the call for measures that really sets the scope. So that's where I think we need to have some clear delineation of what's okay and what's not.

Bobby Pestronk: This is Bobby. You know, it's almost as though having to think about the model in a linear fashion is what's confusing. And the analogy that I've got in my head is it's really more like a magnet. And when you have - and a bar magnet.

Somehow in a bar magnet you go from a positive pole through some neutral space to a negative pole. And the call for measures is really - it's about two things simultaneously which are - which we could weigh differently.

And one is the call for outcome measures - health outcome or outcome measures. And the other is the actual call for equity measures if you will.

And the equity measures - that's ultimately if we believe the model that we're talking about, which is that equity is ultimately the biggest contributor to health outcomes and is the most important one for us then that's what should be weighted highest with the highest priority even though model it may sit all the way over on the left hand side.

And at least the model I was suggesting would be the change I was suggesting for the model that Matt gave us.

Kurt Stange: So this is good - these are important things for the two committees to work on. Elisa you were about to open it up for public comment and I actually wonder if Peggy Honore is - I think she was one of the people on.

And I wonder if she could - has any comments on the scope question as well as anyone else of course.

Mike Stoto: Right. This is Mike. I have to run unfortunately. But could I just make one more comment? It's - I find it useful to think what's the purpose of the set of measures.

And I think one of the key purposes for these population health measures that we are working towards is the new IRS regulations for nonprofit hospitals and so on about doing community health needs assessments.

And I think that one, you know, criteria could be, you know, one issue could be can we give guidance to the hospitals who have to do those CHNAs and the improved community improvement plans that come after those things. And what kinds of measures would be appropriate for those settings?

Kurt Stange: Thank you. Elisa?

Elisa Munthali: Hi. Kelcey, could you open up Peggy Honore's line please?

Operator: Absolutely.

Elisa Munthali: Or all lines?

Operator: Yep. Go ahead Peggy.

Peggy Honore: Oh, okay. I hope it's appropriate because I did hear Kurt mention my name. But anyway, I would like to comment on what Michael just mentioned about community benefit of tax exempt hospitals.

I'm not really sure within the scope of this project if anything could be so specific to just tax exempt hospitals. But I can give you an illustration on how the work that we're doing relates to measures and quality of tax exempt hospitals.

And that is that the tax exempt hospitals, the Catholic Health Association has just endorsed the (ashes) quality characteristics and priority areas as a means of identifying and measuring the work that the - the work - the community benefit and the community building work that they do.

So from a scope perspective, you know, I think as long as there are things that are built into the model that can be used to measure those kinds of things collectively across the system I'm not sure that you need something specific just for tax exempt hospitals.

Kurt Stange: Right but they - so it sounds like they might be among the user groups.

Peggy Honore: Yes. Definitely the tax exempt hospitals. And I can send to you too - the paper that was just published on that with them endorsing the contract.

Elisa Munthali: Please do Peggy.

Female: That would be great. I would be happy to share it with the committee. Are there additional public comments?

Kurt Stange: Well Helen we haven't left you much time left for the upcoming call for measures. But what can you tell us?

Helen Burstin: Oh, actually we have plenty of time. So just to orient people to the materials we sent out to you, we sent you both a sample of what it looks like.

We sent you a sample of the draft call for measures we've been working on for disparities, that should go out shortly, which we thought might just put this ((inaudible)) a call for measures into context a bit.



We also included for you in the PDF the commission paper that was done for us by Mass General and (Joe Betencourt) on disparities and disparities measurement. I thought that might be helpful as well. So I think one of the next steps here would really be for us to consider how we want to draft this.

And it sounds like there is some initial work still to be done by the framework committee. I think the - and the measure evaluation workgroups.

And I think we'll - we'd happily take a crack at drafting that but would also be happy to have a couple of volunteers perhaps from the workgroup, from the broader steering committee who would like to maybe just help us, you know, bounce a couple of ideas off before we share it more broadly.

So our plan is at this point we're going to take the output from the framework scope committee, particularly around scope and suggestions as well as the evaluation criteria and try to craft at least in general language, as to what a call for measures would look like.

We'll also continue to have some discussions with HHS. Actually I've got a call with Peggy and her team on Monday to really get a better sense of scope as well. We had initially talked about trying to pick just a few areas to begin with at least initially thinking about obesity, physical activity and smoking.

And I think we need to think about how we want to handle potentially a broadening of scope or going beyond to outcomes as well since we'll have a project on patient report outcomes in the coming year as well. So that's kind of just the big picture of this.

We'd like to try to as much as possible make the call for measures detailed enough so that the measure community knows what we're seeking.

And one of the important roles for this group as well would be to help us then identify where you think the good measures are that we should go after and bring in as part of this process. I think that's all I'll say to start with. Kurt?

Kurt Stange: If you'd like (Paul) or me to join you and Peggy for the call on Monday that would be helpful so that I think if we have a better handle on the scope we'll be more effective working with the committee. So either talking afterwards or talking as part of that I think we'd both be happy to do that.

Helen Burstin: Yeah. I think we've got some broader issues to talk about as well. So yeah, I think...

Kurt Stange: Okay.

Helen Burstin: ...we'll definitely touch base afterwards and see. But again guidance from the committee as the framework scope group continues to go will be helpful as well as we kind of iterate back with HHS.

Other thoughts from the group about - have you had a chance to for example, look at the call for measures on disparities?

We would include a lot of the key background materials so it'll work, you know, Bobby's been doing and Matt's been talking about regarding how, for example, to include definitions, to include a framework and then to try to give at least some bulleted ideas of what we think the highest priority areas are that we'd like to bring measures in for.

Kurt Stange: One thing I'd take for the call on Monday is just thinking about what might it mean if we did call for at least as part of the some measures of the actual health, some measures of the health of a population rather than just some of the determinants of health.

What might be the transformative potential of that?

Matt Stiefel: Are you asking a question of the group or is it...

Kurt Stange: No. I'm just suggesting - I'm just planting a seed for the call that Helen and Peggy have on Monday.

Helen Burstin: Although feel free to take that as a question Matt.

Matt Stiefel: Well I - it has the potential I think to transform healthcare delivery systems to think about a whole different outcomes framework and about how investments are made in healthcare delivery if the objectives are somehow related to improving length and quality of life.

We may have very different emphasis in the healthcare delivery system. So I think it has potentially quite transformative potential power.

Kurt Stange: The way I look at the decisions that governors for example, are having to make across the country they are having to choose between funding the healthcare for just their government employees let alone other healthcare entitlement programs.

And they're, you know, do they - how much do they fund that and how much are they stealing from education, environmental and other determinants of health?

Matt Stiefel: And I know it's a sensitive issue but we spend a large percentage of healthcare dollars on care near the end of life. And if our frame had to do with the outcomes of length and quality of life it may change our perspective on the relative value of those investments.

Madeline Naegle: That is - it's Madeline. Those are very sensitive issues but I think they're very important ones around the whole issue of expectations about palliative care and what it is and what it can do about quality at end of life. You don't really pay very much attention to that.

And I think that that would be an area to consider in one way or another, around the fact that disparities in opportunities for palliative care are pretty (march).

Bobby Pestronk: Kurt, this is Bobby. I have a question about the long document. I'm trying to go back to the beginning that we're talking about the commissioned paper on healthcare disparities measurements. Are - and this is really I guess for the NQF staff. Is the document like this what Los Angeles is producing?

Female: Yes. That's our hope.

Bobby Pestronk: Okay. In certain parts of this document they haven't shied away from suggesting measures which are what we were talking about earlier as...

Female: Sure.

Bobby Pestronk: ...expanded scope measures. It looks to me as though in some cases they've actually suggested that they could be used.

Matt Stiefel: Yeah. Bobby, this is Matt. It also - I got a similar reaction. This is not just an example. It is germane to the work of this group.

And it raises the question about the overlap of the disparities measures and the population health measures especially given this conversation we've had about the importance of equity and disparities in population health that - this is not just an example for our work.

But there may be significant intersections with the...

Bobby Pestronk: It could also make things - it may also make free - because this work has been produced it might free us to move to the broader question if we think that the kinds of measures that are going to come in here would be I'll just say less broad in the context of the discussion that we've been having.

The talk - so does that make any sense?

Matt Stiefel: Yeah, well for - a question for NQF staff, do you see the distinction being that the disparities measurement call for measures is about narrowly defined as disparities in healthcare delivery? Is that a distinction between the two?

Helen Burstin: Not necessarily, although I think that was logically going to be I think where we think most of the measures are. And again there aren't that many measures that we're aware of out there that are more cost cutting and disparities in cultural competency.

But again, you know, from our perspective if we have overlapping measures come in across two projects we'll just sort it out. It's not a problem from our end. And in fact the call for measures may not be off. They may just be off by about a month. We'll probably have a fair amount of overlap.

And Elisa's involved in both of them so we'll make sure this works.

Kurt Stange: Well it's - my clock's just clicked over to 5:00. Elisa would you like to summarize what you've heard as far as next steps for us?

Elisa Munthali: Sure. Sure. I'll ask Kristin to go to the next two slides. And much of this was mentioned already but the two workgroups have some initial work to do first before we come to a consensus and bring everything forward to the full group.

So we'll be working as we have been doing, closely with the committee, the workgroups and LA County to make sure that we're all receiving the same amount of work and information and that the work is being shared.

I wanted to also mention that during the evaluation workgroup they had suggested that they might want an additional call to work through a population level example.

We didn't have enough time to do that so what staff will do tomorrow is send out a survey (monkey) similar to what we've done for other meetings, to ask for your availability perhaps in the next two weeks for maybe about an hour, an hour and a half, to go over that example.

And we've already talked about the call for measures and our next steps there. I also wanted to talk a little bit about next steps for the provider level measures. These are the preventative services and immunization measures.

I just wanted everyone to know that the majority of developers have submitted their responses to your inquiries and recommendations. And we are compiling those responses and we'll forward those to the workgroups.

Now these are the initial workgroups that we're looking at screening measures and immunization measures.

And so we'll forward those to the workgroups probably beginning of next week so that they can continue their evaluation and vote online on the sub criteria and on the major criteria for all of those measures.

And we're hoping that we can get back responses from the workgroup members by October 19th. After we receive the responses from the workgroups we will compile all of those. That includes the vote and the comments. And we'll forward that to the full committee by October 21st.

And then the committee will have to vote on the four major criteria only and then render an endorsement recommendation for all of the measures. And we're hoping that we can get all of that done by October 31st. So we still have quite a bit to do but I think we'll be able to get through it.

We're trying to build in enough time in there for you to review the responses from the developers and for you to be able to go online and enter your votes and any comments that you have on these measures. Are there any questions?

Kurt Stange: Just two other things I heard and maybe you said this in a way I didn't understand. People will be sending - committee members and Dawn will be sending you relevant materials that you will collate and get out to us and then you'll be setting up some working group follow up meetings.

And I'm fairly clear on the framework committee's charge. Sarah, do you feel like your group needs another meeting?

Elisa Munthali: Sarah?

(Sarah): Yeah, I'm here. I'm just trying to think through it. You know, I guess, you know, to some degree as I recommended or, you know, kind of threw out there on our call yesterday is that it might be nice to meet to kind of do a test drive of the criteria.

But, you know, I would defer to the other members of the workgroup if they'd be interested NAD have the time to do that.

Kurt Stange: And I'd also wondered is Helen - Helen suggested that she and her staff will be working on an initial draft call. Did you want to work with them or do a couple of members of the group want to work with her on that?

(Sarah): We think that's a good idea.

Female: Could we do that as kind of a survey (monkey) and could you just send it out and have folks who want to do it sign up?

Female: Yep.

Female: Yep.

Female: We could do that. Good idea.

Female: I just got assigned a really big project so I'm just a little bit - until I figure out what it is and what it's going to take of me I can't commit.

Female: And I actually think much of the work on that group can actually be done via email or just for the area processes. So I think we'll be okay.



Kurt Stange: Okay, great. So Elisa you'll be sending us out some additional materials in addition to the ones we already have and we'll be thinking (consolidatively) around those for the framework groups.

And the measure group will be working - it sounds like we'll be working with you on maybe getting a draft call for measures just so we can see what it might look like and have something to kick around.

Elisa Munthali: Yes.

Kurt Stange: Okay. And then we'll have this other - these other tasks that you'll be sending us, things that we'll do mostly remotely it sounds like.

Elisa Munthali: Yes.

Matt Stiefel: It's Matt. I wasn't clear about the - for the framework workgroup will you, NQF staff, be helping us schedule another meeting or what's the status with that?

Helen Burstin: Yep.

Elisa Munthali: Yes.

Matt Stiefel: Okay.

Elisa Munthali: We will.

Helen Burstin: We'll take care of it.

Matt Stiefel: Okay.

Helen Burstin: So it sounds like we're - this is Helen. We're going to have a fair amount of materials to package so we'll wait until we get stuff in, pull it together and then repackage it and send it back out to you. Hopefully we'll organize it in a way that's a little bit easier, as a reference document.

And just one thing, if people didn't notice, the PDF today was bookmarked. If you're looking at it and the bookmarks weren't apparent just click on the little tab on the left that looks like a bookmark. We try to do that to make it easier to read.

We'll also see - NQF recently adopted SharePoint so we'll also see if perhaps there's an opportunity for us to get a SharePoint site for the steering committee so we can post all the documents and you can have more of a better virtual space to work in.

Kurt Stange: Great. Well thanks everybody for staying over and for the call - things moved this forward and I think we're starting to get on the same page here so that feels good.

Helen Burstin: Yeah, I think so. Great.

Elisa Munthali: Thank you very much.

(Crosstalk)

Elisa Munthali: (Sean)?

Kurt Stange: Elisa, this is Kurt. Do you want me to hang on or do you just want to talk...

END