

THE NATIONAL QUALITY FORUM

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MEETING OF THE CHILD HEALTH

STEERING COMMITTEE

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Thursday, November 12, 2009

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The Child Health Steering Committee met in the Ambassador Room of the Hilton Washington Embassy Row, located at 2015 Massachusetts Avenue, N.W., Washington, D.C., at 10:00 a.m., Charles Homer and Marina L. Weiss, Co-Chairs, presiding.

PRESENT:

CHARLES HOMER, MD, CO-CHAIR  
MARINA L. WEISS, PhD, CO-CHAIR  
DAVID R. CLARKE, MD, MEMBER  
SHARRON L. DOCHERTY, PhD, CPNP (AC/PC), MEMBER  
KATHY J. JENKINS, MD, MPH, MEMBER

ALLAN S. LIEBERTHAL, MD, FAAP, MEMBER  
THOMAS McINERNY, MD, MEMBER  
MARLENE R. MILLER, MD, MSc, MEMBER  
LEE PARTRIDGE, MEMBER  
JANE PERKINS, JD, MPH, MEMBER (via telephone)  
DONNA PERSAUD, MD, MEMBER  
GOUTHAM RAO, MD, MEMBER

ELLEN SCHWALENSTOCKER, PhD, MBA, MEMBER  
BONNIE ZIMA, MD, MPH, MEMBER  
HELEN BURSTIN, STAFF  
IAN CORBRIDGE, STAFF  
MELISSA MARINELARENA, STAFF  
ASHLEY MORSELL, STAFF  
EMMA NOCHOMOVITZ, STAFF

REVA WINKLER, STAFF  
BONNIE ZELL, STAFF

NOT PRESENT:

NANCY L. FISHER, MD, MPH, MEMBER

FAYE A. GARY, EdD, RXNORM, FAAN, MEMBER

PHILLIP KIBORT, MD, MBA, MEMBER

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

2 9:58 a.m.

3 CO-CHAIR WEISS: Good morning  
4 everybody, if we could begin. Maybe everybody  
5 take their seats and let's get started. I'm  
6 Marina Weiss and I'm co-chairing with Charlie  
7 Homer who has a phone call that he has to do  
8 right now, but he'll be with us shortly.

9 And if you don't mind, I'd like to  
10 hold introductions and descriptions of how  
11 you, the path by which you got here until  
12 Charlie arrives so that he too can hear that.  
13 But I think we have some -- I'm not sure  
14 exactly what Reva has in mind for us today,  
15 but I think she's going to lay out some  
16 general perimeters for the meeting. And so  
17 let me turn it over to Reva Winkler.

18 OPERATOR: Ms. Marinelarena?

19 CO-CHAIR WEISS: Yes.

20 OPERATOR: Hi, this is the  
21 operator handling your call today, are you  
22 ready to be transferred into the main

1 conference?

2 CO-CHAIR WEISS: Yes, we are.

3 OPERATOR: Okay. I'm going to  
4 transfer you now, you'll hear music for just  
5 a moment and when that disappears you can  
6 begin.

7 CO-CHAIR WEISS: Thank you so  
8 much.

9 DR. WINKLER: Hello, is someone on  
10 the phone? Anybody there? Okay. Hi  
11 everybody, I'm Reva Winkler, I'm one of the  
12 NQF staff members, part of the project team  
13 that's overseeing this project that you so  
14 graciously agreed to part of with us.

15 What we're going to do in these  
16 two days is several things, we want to get you  
17 up to speed on what NQF is doing these days,  
18 we're a growing organization, some of you are  
19 familiar with our work, you've worked with us  
20 in the past, some of you less so and we'd like  
21 to get everybody sort of in the same place and  
22 understanding what NQF does and particularly

1 what our work in this particular project is.

2 As well as we have a couple of  
3 tasks for this committee to do to help us set  
4 the directions and the subsequent activities  
5 for this project. And we are focused around  
6 outcomes. This is -- this effort is part of  
7 a larger project that is funded by the  
8 Department of Health and Human Services around  
9 patient outcomes.

10 We actually have it broken up into  
11 several pieces, one -- the largest piece of it  
12 is focused in on adult outcomes around sort of  
13 the top 20 Medicare conditions, if you will,  
14 certainly a big focus of the Agency. But in  
15 addition to that, we also have -- and they  
16 have their own steering committee and  
17 technical advisors and all of that.

18 But in addition to look at some  
19 other areas, we also have a steering committee  
20 for mental health conditions, primarily  
21 Alzheimer's disease, depression and those sort  
22 of serious mental illnesses because that's a

1 slightly different area, so it has its own  
2 steering committee and then you all to look at  
3 child health.

4           And so while you're part of a  
5 bigger project, you are essentially the  
6 decision making body. And we'll talk about  
7 the role of the steering committee a little  
8 bit more later in the morning, but our focus  
9 will be on looking outcomes for child health.

10           So what I'd like to do, and we'll  
11 break whenever Charlie arrives so we can do  
12 the introductions, is just kind of start out  
13 with sort of an orientation to NQF and some of  
14 the things that we think you should be aware  
15 of to make it easier for you to be a member of  
16 the steering committee and understand what  
17 we're asking of you and to play that role.

18           So this is what we're going to be  
19 doing today. The goals of this two day  
20 meeting is to do this orientation and we are  
21 going to discuss the scope of this project,  
22 what do we mean by child health outcomes.

1           This is going to be one of the, I  
2 hope, one of the more interesting discussions  
3 that we have this afternoon and tomorrow. And  
4 then we'll just talk about NQF standard  
5 measure evaluation process rather briefly.  
6 Okay, Melissa the next one.

7           So just I'm sure all of you are  
8 aware of what NQF is, but just as a very, very  
9 brief summary we are a non-profit  
10 organization, we are a membership  
11 organization, we have over 400 members now  
12 representing a wide variety of stakeholders.

13           We are specifically a multi-  
14 stakeholder organization around issues of  
15 quality measurement in health care. Our  
16 structure is a typical non-profit structure,  
17 but there are a couple of interesting aspects  
18 of it.

19           The Board of Directors oversees  
20 all of our work, but our Board of Directors  
21 contains representatives from government  
22 agencies. We do have a subcommittee of the



1 board that's very important in the process,  
2 that you will be working with, is the  
3 consensus standards approval committee.

4           And then we also are working very  
5 closely with the National Priorities  
6 Partnership and we'll talk a little bit more  
7 about that. And then our leadership network  
8 is the chairs and vice chairs of each of our  
9 member councils to provide input and advice  
10 through those specific stakeholder groups.  
11 So, next.

12           This is a screen shot of NQFs new  
13 website, and I would encourage all of you to  
14 go there. And you can see that you, over on  
15 the right-hand side, you can enroll as a  
16 member, anybody can, there's no qualifications  
17 besides willingness to fill out the form, to  
18 give yourself a log-in a password and access  
19 to it.

20           Because you can create your own  
21 dashboard so that when you log in, all the  
22 things that are of interest to you within the

1 very NQF website, will come up and you'll be  
2 able to see them without going through all the  
3 different screens.

4           So this particular project is  
5 phase III of the outcomes project, child  
6 health, so you might want to put that on your  
7 dashboard as well as whatever else interests  
8 you that we may be doing.

9           And I encourage you to kind of  
10 search through that website because there's  
11 just an awful lot of stuff in there. NQF has  
12 an awful lot of activities, we're going to  
13 touch on a few of them in the next few  
14 minutes, but it's fairly wide ranging and you  
15 might be interested in some of the other  
16 aspects of NQFs activities. And so I  
17 encourage you to register and check in with  
18 us.

19           But it will be a way to follow the  
20 process that we're going to take measures  
21 through for child health. Next one.

22           Just -- we've given you a copy of

1 the slides, every organization has a mission  
2 and vision statement, this one is ours. And  
3 essentially we have a three-pronged mission.

4 And one is improving the quality  
5 by setting our national priorities and goals,  
6 and we'll talk more about the National  
7 Priorities Partnership as an activity for  
8 that.

9 The second bullet is really the  
10 action that we're working on, and that's  
11 endorsing national consensus standards for  
12 measuring and publically reporting on  
13 performance within the health care system. So  
14 this is the work we are doing.

15 And then, we also have activities  
16 around promoting the goals through education  
17 and outreach programs. So these are the sort  
18 of big sort of buckets of activities that NQF  
19 pursues and you're working primarily in the  
20 second one. Next one.

21 Again, just to show you our,  
22 generally our strategic goals is NQF

1 essentially endorses -- is the principal body  
2 that endorses national health care performance  
3 measures, quality indicators or quality of  
4 care standards.

5           So that's -- those are our  
6 strategic goals, that's sort of our role in  
7 this, the quality enterprise in this  
8 landscape. Through measurement we are  
9 striving to improve the overall health care  
10 system and by the contributions of endorsing  
11 measures standardizing measurement on a  
12 national basis, we are carrying out our  
13 various missions.

14           NQF is now 10 years old. We  
15 celebrated our 10th anniversary this year and  
16 I've been around for nine years of it. Though  
17 it's a rapidly growing organization, Marina I  
18 think you've been around for 10 year of it,  
19 from the very beginning. No, she's been there  
20 even before me, from even before I think when  
21 it was a twinkle in somebody's eye.

22           NQF has done a lot of work in that

1 10 years. Over that period, the focus has  
2 been on evaluating and endorsing measures as  
3 national voluntary consensus standards. There  
4 is a growing and continually urgent need for  
5 more measures.

6           It's also an evolutionary process,  
7 it's not just essentially more measures as a  
8 volume, but better measures as time goes on as  
9 everyone embraces measurement and the  
10 information we gain from it can be used to  
11 drive quality improvement, better measures,  
12 more robust measures, different kinds of  
13 measures than we initially started out with  
14 are needed.

15           So this is a constantly evolving  
16 process, it's not a matter of numbers. So  
17 currently at this point there are several  
18 drivers that are driving the work we do.  
19 Measurement -- measures are needed for  
20 accountability programs of various kinds  
21 whether they're public reporting, whether  
22 they're pay for performance, whether they are,

1 you know, any other kind of incentivization or  
2 accountability program.

3           Certainly within the measures that  
4 we've looked at over the years, there are gaps  
5 that need to be filled. Certainly many  
6 stakeholders identify, you know, it's great  
7 that you've got these measures, but we need  
8 measures that do this or provide this kind of  
9 information and there are large gaps.

10           We've been working on filling the  
11 gap for measures suitable at the individual  
12 physician level, that's essentially the work  
13 I've been doing for the last three or four  
14 years and we now have a significant number of  
15 measures across a large variety of conditions  
16 that can be used at the individual level.

17           Disparity sensitive measures.  
18 Issues around disparities are a continual  
19 concern and how do you use measurement to help  
20 us understand that. There are certainly  
21 measurement challenges around how do you --  
22 getting the appropriate data to allow you to

1 stratify results.

2           But certainly keeping disparities  
3 front and center as an issue and a concern  
4 around measurement is definitely one of our  
5 priorities. Patient experience in many  
6 settings, we do have -- we have endorsed  
7 multiple tools for assessing patient  
8 experience with care, some for children, some  
9 for adults, some for hospitals, some for  
10 outpatient.

11           There are probably areas that  
12 still need to be addressed, but it is an  
13 important area to get the patient perspective.  
14 And then crosscutting areas that aren't so  
15 much disease or condition specific, but would  
16 apply to all patients either and particularly  
17 across settings.

18           So there are still a lot of areas  
19 of -- where measures are needed. And that's  
20 going to be one of the issues we're going to  
21 ask you to help us deal with, particularly as  
22 it pertains to child health outcomes. We need

1 to figure out how to describe, in a framework,  
2 if you will, you know, all the aspects of  
3 desirable outcomes.

4           How do we figure out what we have  
5 and what we need? We need some sort of a  
6 structure to be able to organize it so that we  
7 can either identify existing measures to know  
8 that they'll fill one of these slots within  
9 our organizational structure or our framework,  
10 or if they have not been developed, how do we  
11 identify that specific need for measure  
12 development.

13           So these are the primary goals for  
14 our project around child health. A couple of  
15 key issues as we've reached our 10th year,  
16 our portfolio of measures contains about 550  
17 measures and I just completed a project that  
18 allowed another 70, so we'll top 600  
19 relatively soon.

20           And the question is, you know, is  
21 it too many, is it too few, but more  
22 importantly are they the right measures.



1                   And I think we're seeing, as we're  
2 going through our measures maintenance  
3 process, that some measures that seem  
4 perfectly fine five years ago really don't  
5 have a great deal of utility now, they've been  
6 superceded by better measures or they're  
7 topped out, they aren't being used, they  
8 aren't found to be particularly great drivers  
9 of quality improvement.

10                   So, this portfolio needs to  
11 undergo constant review and modification  
12 revision updating. So it is a work, always a  
13 work in evolution, it's not a static thing.

14                   Another thing that's changed over  
15 the 10 years that NQF has been endorsing  
16 measures is data sources, you know, there are  
17 some traditional data sources, but there are  
18 new data sources. We're getting perhaps  
19 closer to having sort of the ultimate data  
20 source through electronic health records.

21                   That certainly is not without its  
22 challenges, but there seems to be an

1 accelerated focus on using of -- getting to  
2 the point where there are EHRs out there with  
3 the capability of supporting performance  
4 measurement.

5           So all of these things overlies all  
6 of the work that we do. So we need to keep  
7 those in the back of our minds as  
8 considerations as we're looking at how do we  
9 measure outcomes for children.

10           Okay. Again as I mentioned 10  
11 years of experience, we are evolving. We get  
12 feedback from all of the various stakeholder  
13 members in terms of what their needs are out  
14 there for measures. They want to use them,  
15 they want information, what do we need.

16           We need measures that drive us to  
17 higher performance. Measures that basically  
18 say hey we're doing a good job, you know, 98  
19 percent compliance aren't really very helpful  
20 because they're not very actionable. So  
21 they're not going to be driving. So there  
22 isn't a great deal of enthusiasm for those

1 kinds of measures.

2           Shifting towards composite  
3 measures, another strong message we're  
4 hearing, how do we package information in ways  
5 that make it easier for all sorts of  
6 stakeholders, but particularly consumers and  
7 purchasers to really understand the value of  
8 the care that they may be getting or paying  
9 for.

10           Among the composites are concepts  
11 around like the perfect care measure, did this  
12 -- did a single patient get all five elements  
13 of appropriate diabetes care, you know, how  
14 many of your patients received all of them.

15           Way to take measures that are all  
16 -- looking very good on performance across the  
17 board, but ask the question somewhat  
18 differently, raise the bar a little higher and  
19 suddenly there's room to improve. So pushing  
20 these measures farther is certainly the  
21 message we're getting.

22           I had already mentioned

1 disparities, so we really want to think about  
2 how do we tackle the issues around disparities  
3 in the measures that we do.

4           So when we're looking at the  
5 measure specifications, when we're talking  
6 with the measure developers, when we know it's  
7 a condition that disparities play a role, we  
8 need to really dive in and ask how can we use  
9 this measure to help us understand more about  
10 disparities and potentially drive change  
11 around those disparities.

12           Another huge message we're getting  
13 is harmonization and if that's a new term to  
14 you, harmonization is the idea of aligning all  
15 measures that address a similar issue. For  
16 instance, all measures around diabetes.

17           The definition of who's included,  
18 the diabetic by age, by whatever coding you  
19 use, shouldn't vary, even just the littlest  
20 bit from one measure to the next. Either  
21 you're measuring the same group or you're not.

22           So that harmonization, but we've

1 come to a place where various measure  
2 developers have developed their measures for  
3 a wide variety of reasons and potential uses.  
4 And so they were working independently and  
5 ended up, oh just a little different.

6           To try and pull these together in  
7 a harmonious group, we really need to try and  
8 foster alignment along those measures to the  
9 degree possible. Certainly, age inclusions  
10 are an important one, but some of the  
11 definitional issues of who's included in a  
12 denominator for any particular condition,  
13 who's excluded, those sorts of things; real  
14 important aspect of harmonization.

15           We're hearing from the people who  
16 want to use the measures out in the field that  
17 without that harmonization, it's just too hard  
18 for them to implement a measure that's, you  
19 know, this one's this way and the next one's  
20 slightly different. So that's going to be a  
21 very important overlay to what we're doing.

22           And we certainly want to see more

1 measures that promote shared accountability  
2 and measurement across episodes of care and  
3 certainly across the continuum of care in all  
4 settings.

5           To that end, outcome measures are  
6 a critical aspect. That's why you're here.  
7 Finally, people are willing to, you know,  
8 let's talk outcomes.

9           For the longest time, process  
10 measures have been the focus, the comfort  
11 zone, but the need to really start talking  
12 about where it counts, what patients care  
13 about what, purchasers care about and  
14 ultimately all providers and professionals  
15 should care about or what ultimately happens  
16 to the patient, what are the outcomes. So  
17 that's why we're here.

18           Other issues that we want to try  
19 and tackle are appropriateness measures, you  
20 know, having a surgery go well and without any  
21 complications are great, but did you need it  
22 in the first place. Those questions need to

1 be addressed, still in its infancy, I'm  
2 afraid.

3 Cost and research measures coupled  
4 with quality measures, definitely. Big, big  
5 interest in that, particularly in the consumer  
6 purchaser plan, you know, folks. And I think  
7 it's something everyone needs to be aware of  
8 and interested in because health care costs  
9 are just really quite high.

10 So those are the kinds of issues  
11 around quality measurement that NQF is trying  
12 to focus on. We want to keep these in mind as  
13 we do the work of this project because we do  
14 want -- one of the roles of the staff is to  
15 try and keep all of you aware of all the other  
16 NQF activities that are ongoing, to keep  
17 everything aligned.

18 We don't really want to function  
19 in silos or black boxes, we need to know  
20 what's happening in other aspects of the  
21 organization.

22 Just a brief expanse in

1 disparities. We've had numerous conversations  
2 and efforts around disparities and so several  
3 conclusions that I want you to be aware of as  
4 we go forward looking at potential measures,  
5 certainly there are a lot of measures  
6 pertaining to child health where disparities  
7 are a significant concern.

8           And so sort of the initials are  
9 principles around looking at disparities is  
10 that assessment of the potential ways you may  
11 characterize patients by race, ethnicity,  
12 primary language, SES status should be routine  
13 in performance measurement.

14           And again I think for every -- any  
15 measure that we see, we ask the question have  
16 you considered it and if not, why not and how  
17 can you -- how could you consider it in  
18 implementing this measure.

19           Certainly there are challenges in  
20 collecting the data, and so exploring the data  
21 collection methods for gathering the  
22 information you need to do that.



1                   And then particularly identifying  
2 those measures that are particularly disparity  
3 sensitive that we know there are issues around  
4 disparities and really try and drive to those  
5 measures being stratified -- being able to be  
6 stratified by these various perimeters such  
7 that we can get better information on  
8 disparities and monitor and trend and  
9 understand performance and changes over time.

10                   Another phrase I mentioned in a  
11 previous slide was episodes of care. And  
12 rather than looking at real point in time  
13 issues where measures are easier to do and  
14 have been more common in the past, we want to  
15 look at things from a patient perspective and  
16 that's an episode.

17                   I mean, it didn't just happen in a  
18 single doctor's visit from the patient's  
19 perspective, it happened over a period of time  
20 and for those with chronic conditions, over a  
21 long period of time.

22                   And so one of the efforts that NQF

1 has been undergoing over the last several  
2 years has been looking at some of the more  
3 common conditions around episodes of care and  
4 creating episode of care frameworks.

5           And this is an example of a  
6 framework around acute MI, it also happens to  
7 encompass coronary artery disease when you  
8 look at the first bubble. These are our  
9 bubble diagrams, I've actually been in the  
10 audience at any number of meetings and people  
11 have been using our bubble diagrams to sort of  
12 demonstrate this concept of an episode of  
13 care.

14           So this is a concept that's  
15 growing and finding its way out into the  
16 world. And we plan on using this in some of  
17 the outcomes work around certain conditions.  
18 I'm not sure exactly if we could use it around  
19 child health, we'll have to think about it.

20           But certainly looking at the  
21 various phases that a patient experiences  
22 under certain conditions, and these help us

1 identify what the outcomes of interest are.  
2 What happens to these patients as they  
3 progress through the various phases of their  
4 disease or condition and what are going to be  
5 the outcomes of interest for that episode of  
6 care.

7           So this is a framework that we're  
8 using a lot and at this point it isn't clear  
9 to me that it is something we will use in  
10 child health, but if you guys can help me  
11 figure out a way to do that, I'd like that.

12           Right now it's not -- I can't  
13 quite figure it out, but with all the good  
14 minds around the table perhaps we'll be able  
15 to. So I wanted to make you aware that this  
16 is something, a tool that we are trying to use  
17 to the greatest degree possible. Next one.  
18 I'm going to take a deep breath. Okay.

19           I also mentioned the need for a  
20 national priorities and goals, certainly as  
21 one of NQF's missions. This is a focus on  
22 finding the high leverage areas that can drive

1 the greatest amount of improvement for the  
2 effort and the investment made.

3           We want to align the efforts of  
4 all sorts of people. The quality measurement  
5 enterprise is a large one, there are lots of  
6 organizations working in this space, and if we  
7 all work together we're likely to make much  
8 more progress than if everybody's doing their  
9 own thing.

10           Certainly individual efforts have  
11 been, you know, wonderful and successful but  
12 if we can just pull those all together I think  
13 we can get some exponential progress and  
14 accelerate where we're trying to go.

15           So about two years ago NQF was  
16 involved in working with a group of partners,  
17 32 organizations, very -- you can probably  
18 name them, but across the stakeholder  
19 landscape organizations that are very much  
20 invested in quality measurement and improving  
21 health care quality.

22           They established the National

1 Priorities Partnership, NQF is one of the  
2 partners, but so are a lot of other folks. It  
3 is a multi-stakeholder group, it's co-chaired  
4 by Don Berwick from IHI and Peggy O'Kane from  
5 NCQA.

6           So this is an activity that NQF is  
7 very much involved in, working with the  
8 partners to align all of these efforts. Next  
9 one.

10           The work of the National  
11 Priorities Partners over the last two years  
12 since they launched their activities was to  
13 try and identify priority areas and goals to  
14 focus on so that with everyone looking towards  
15 the same priorities, same goals to build on  
16 and have sort of an accelerated additive  
17 effort.

18           Their analysis of various types of  
19 measurement, the potential areas and  
20 priorities they were able to identify the high  
21 impact areas and those are, they came up with  
22 six priorities, all right.

1                   For those of you who have been  
2 working with the Priorities Partnership, I'm  
3 sure these are very familiar to you, for those  
4 who are not, it's important -- this is an  
5 important work that NQF is doing in trying to  
6 align a lot of the work with the partnership.

7                   The first priority area is to --  
8 is around care coordination, cost providers  
9 settings and levels of care. The particular  
10 current goals are around medication  
11 reconciliation, preventable hospital re-  
12 admissions and preventable emergency room  
13 visits.

14                   So that's -- you'll see in a great  
15 many of the work -- a lot of the work that NQF  
16 does regardless of the project, these are the  
17 kinds of measures that are very important ones  
18 and we do flag then as being aligned with the  
19 National Priorities Partnership's priorities  
20 or one of the goals. You'll also see that in  
21 our evaluation form when you do measure  
22 evaluation.

1           The second main goal is in  
2 population health, improving preventive  
3 services, healthy lifestyle behavior with  
4 ultimately -- with an ultimate goal of  
5 creating a population or community health  
6 index to better understand what's going on, on  
7 a bigger picture.

8           And I'd like to introduce one of  
9 our newest colleagues to NQF, Dr. Bonnie Zell,  
10 Bonnie wave to the folks. She's leading up  
11 our efforts around population health and  
12 she'll be talking with you later this  
13 afternoon about how do we think about  
14 population health and children's health.

15           How do those two come together,  
16 how can we find perhaps meet some of the needs  
17 of the population goal or priority at the same  
18 time as we're looking at child health  
19 outcomes. So we want to keep that in mind.

20           Another of the priorities is  
21 around patient safety. Patient safety, huge,  
22 huge issue. We have a lot of activities

1 within NQF around patient safety. Certainly  
2 the goals in this particular NPP area are  
3 around mortality, serious adverse events and  
4 health care associated infections.

5           Those are sort of the big ones,  
6 but if you're aware of NQFs work in the area  
7 of patient, you know that almost from the  
8 beginning of its existence, we've had projects  
9 around and endorsed the serious reportable  
10 events, and it's a growing list.

11           We've also endorsed the safe  
12 practices and they've been revised and updated  
13 several times. So these are actually NQFs in-  
14 house works and has been sort of the backbones  
15 of NQF as a growing organization. So patient  
16 safety continues to be a very significant goal  
17 in the work that we do. I must have skipped  
18 something, there we go.

19           The fourth one is patient and  
20 family engagement. A very important aspect of  
21 care delivery, difficult to measure, but  
22 nonetheless, very important. So it's a



1 challenge that the partnership has embraced.  
2 How do we do this? Not necessarily quite sure  
3 yet, but we've got enough, you know, smart  
4 people, good organizations working on it. I  
5 think we can probably make some progress in  
6 that arena.

7           Certainly we need more information  
8 around informed decision making, more patient  
9 experience with care and more around patient  
10 self management. So those issues are  
11 certainly, and measures around those issues  
12 are certainly things that would be very  
13 important and very desirable for us if they  
14 should come across this project.

15           The fifth one is end of life care,  
16 palliative and end of life care, compassionate  
17 care, relief of symptoms, meeting patient  
18 needs and access to palliative care and  
19 hospice services. Certainly an important  
20 aspect of care to be addressed.

21           And then the last of the priority  
22 areas is eliminating ways to -- well ensuring

1 appropriate care. So it's an appropriateness  
2 with some emphasis on overuse. Certainly it's  
3 well acknowledge that there is overuse of a  
4 lot of different aspects of care. Next one.

5           And the potential areas that the  
6 partnership is looking at, are those that I've  
7 listed in appropriate medication use,  
8 unnecessary labs, unnecessary diagnostic  
9 procedures, unnecessary maternity care,  
10 interventions, unnecessary consultations, U.S.  
11 Preventive Services Taskforce de-  
12 recommendations like don't do it, that are  
13 still unfortunately being done, as well as  
14 preventable hospitalizations and ED visits and  
15 inappropriate end of life care.

16           So these are areas that the  
17 partnership is tackling. And if we see  
18 measures that come across this project that  
19 support that priority and goal, we will want  
20 to note them and consider them within these  
21 priorities. Next one.

22           Just to -- the National Priorities

1 Partnership is something NQF is active in and  
2 we support through our convening function, but  
3 it isn't, you know, a wholly owned subsidiary  
4 of NQF. So it is sort of a separate entity  
5 that we work with very, very closely.

6           They have their own website I'll  
7 point you to, a lot of things going on there,  
8 a lot of detail of the goals and priorities  
9 that I just briefly summarized is in there, a  
10 lot of information.

11           So feel free, and I encourage you  
12 to go check that website out to -- so you have  
13 a better understanding of all the stuff going  
14 on with the National Priorities Partnership as  
15 well as a list of the organizations that are  
16 involved.

17           So we've got priority  
18 partnerships, we've got episodes of care, so  
19 let's slam it all together and what do we get?  
20 This is the bubble diagram plus NPP, courtesy  
21 of my boss, Dr. Helen Burstin who we'll  
22 introduce ourselves a little more throughly

1 later.

2           But this is how we're trying to  
3 keep in mind all these different aspects of  
4 the work that NQF does. And so these are the  
5 kinds of diagrams that help us organize our  
6 thinking and organize our work so that we  
7 don't lose site of important aspects.

8           So one of the things that we're  
9 going to be asking you to help us think  
10 through around child health outcomes is  
11 something similar, what are all of the  
12 dimensions, what are all of the domains, what  
13 are all the aspects of care around -- for  
14 child health that we need outcome measures for  
15 to both help us identify those outcome  
16 measures if they exist, or how do we say we  
17 need a measure that looks like this.

18           So that's going to be really the  
19 crux of the project we're asking you to help  
20 us with. Further on in terms of NQF  
21 activities, we're doing an awful lot of work  
22 around IT. Some of the -- led by Dr. Floyd

1 Eisenberg, we're working with several projects  
2 to help the -- accelerate efforts around the  
3 EHR development, what health information is  
4 needed to support performance measurement.

5           There has been a lot of money from  
6 the recovery and reinvestment act for  
7 stimulating use of electronic health records.  
8 We need those records to be developed in a way  
9 that will become very useful for performance  
10 measures.

11           And so we are certainly involved  
12 with all of the variety of efforts both within  
13 the federal government and in the private  
14 sector too, to come to sort of a common place  
15 so that when providers adopt those EHRs they  
16 provide the functionality and they can do all  
17 the things we hope they'll be able to do  
18 because it's not a simple thing.

19           And go to the next one. Because  
20 data is tough. Right now we have a very  
21 complex world, a lot of data, a lot of  
22 potential data streams, lots of need for data,

1 lots of need of data analysis.

2           And so trying to put this into a  
3 package that provides the information out is  
4 a very difficult one but it's something we've  
5 got ongoing activities around.

6           And some of the more interesting  
7 work that we're doing is around the quality  
8 data set. This is a set of data elements that  
9 we've actually created from the measures that  
10 NQF has endorsed to help, you know, how do you  
11 break it down into little pieces into data  
12 elements so that that data could be captured  
13 in electronic platform.

14           Also looking at how is this  
15 embedded in a normal workflow so that  
16 measurement isn't -- is part and parcel of  
17 care delivery and not something that's done  
18 after the fact or as an added burden.

19           These quality -- the quality data  
20 set with these defined data elements in a  
21 standardized fashion, the next step is a  
22 measure authoring tool so that someone who

1 wants to create a measure about something, you  
2 know, you don't redefine patients with  
3 diabetes, there is the definition, go to the  
4 QDS, put that up, fine. Now what do you want  
5 to measure about them?

6           There's a good chance we may have  
7 already had some of those data elements  
8 already defined. Trying to maintain  
9 standardization sort of an up-front  
10 harmonization, if you will.

11           So these are some of the ongoing  
12 activities that probably won't touch us very  
13 directly, but the work we do will impact  
14 because the measures we evaluate and move on  
15 will get fed into the QDS. Any other comments  
16 you want to make about that Helen?

17           Okay. So I'm okay, where's  
18 Charlie? Just because we're running a little  
19 ahead of schedule, we're supposed to be  
20 introducing ourselves and I sort of hate  
21 continuing to talk to you without it. Please  
22 use all of your microphones, we are recording

1 this and there will be a transcript of this  
2 meeting. And that transcript will actually be  
3 posted on our website, so just keep that in  
4 mind.

5 DR. JENKINS: I have a question.  
6 Just in related to what you say, can you give  
7 us a little bit more understanding of in this  
8 process or perhaps in the general NQF process  
9 about the high stakes accountability pay for  
10 performance metrics versus what you also  
11 alluded to earlier is the more quality  
12 improvement perhaps not at that level metrics  
13 and just give us the overall on that.

14 DR. BURSTIN: Of course. So  
15 overall, I'm Helen Burstin by the way, we'll  
16 do our intros shortly I guess. The overall  
17 goal of what NQF does is really to endorse  
18 measures that are appropriate for public  
19 reporting and quality improvement.

20 There's expectation for both. The  
21 public reporting really is the sort of  
22 ultimate goal of many of the NQF endorsed



1 measures. So there may be measures that are  
2 used for internal QI, for example, that  
3 wouldn't necessarily rise to the level of  
4 being able to pass all the four evaluation  
5 criteria that Reva will also go over with you,  
6 of an NQF endorsed measure.

7           So we mainly focus on a higher  
8 level, those higher level ones perhaps as you  
9 refer to them, and one of the reasons this is  
10 especially important is NQF endorsement is  
11 required when the federal government chooses  
12 to seek to use measures for any of their  
13 public reporting programs.

14           There are options that they can go  
15 around it at times, but in general that's been  
16 the case. What's a little unique about this  
17 situation is that much of that work has been  
18 done in the Medicare environment, very little  
19 around children and Medicaid, in particular,  
20 although health plans have certainly focused  
21 on some of this.

22           So I think because of that, and

1 certainly Reva knows the work around CHIPRA  
2 quite well, there's a lot emerging I think  
3 about the way quality measures might get used.  
4 I don't know if you want to mention anything  
5 about sort of the policy landscape or what's  
6 happening with CHIPRA as an important piece of  
7 background as we think about the role of these  
8 measures.

9           CO-CHAIR WEISS: Yes. For many of  
10 you who follow pediatric issues, I'm sure are  
11 well aware that with enactment of the re-  
12 authorization Bill that brings the CHIP  
13 program. Children's Health Insurance Program  
14 forward to the year 2013 that there was added  
15 to that Bill a very robust section, I think,  
16 that moves both the CHIP program and the  
17 Medicaid program so far as it's involved in  
18 covering children toward more aggressive  
19 posture with respect to the development and  
20 use of quality measures.

21           And so that, the implementation of  
22 that section is well underway by the beginning

1 of 2010 there is supposed to be published a  
2 core set of measures that would be used in  
3 both programs and some technical advisory work  
4 has been going on in that regard and there are  
5 things up on the HHS website that you might  
6 want to explore into the AHRQ section and  
7 such.

8           So, that is the first wave of  
9 measures that are supposed to be out there.

10 And as I say, they are a core set, but there  
11 is every expectation on the part of members of  
12 Congress who were involved in putting together  
13 the quality section of the bill and also the  
14 Secretary and folks over at HHS that this is  
15 just step one, that there are many other steps  
16 to come.

17           And they involve, as I say, both  
18 the development of pediatric measures and also  
19 the dissemination and utilization of such  
20 measures in the big public programs. So, we  
21 are operating in that environment as Helen  
22 says. This is an opportune time for NQF to

1 get involved in this, in a big way. I'm happy  
2 to be a part of it.

3 DR. JENKINS: Just for  
4 clarification, do you all use any standard  
5 terminology to distinguish like the lower  
6 level measures from the higher ones?

7 Because I know the American  
8 College of Cardiology uses performance  
9 measures as opposed to quality metrics, just  
10 for communication about measures eligible for  
11 accountability and pay for performance and  
12 public reporting versus things that are not at  
13 that standard or there's no standard  
14 nomenclature you use?

15 DR. BURSTIN: We refer to them all  
16 as quality measures or performance measures.  
17 I think when we specifically refer to them  
18 we're thinking about the measures appropriate  
19 for consideration for NQF would be those that  
20 would be appropriate and could ultimately be  
21 used for accountability and public reporting  
22 programs. There may be other quality

1 improvement related measures, but again, we  
2 don't call them something else.

3 DR. JENKINS: Thank you.

4 DR. BURSTIN: But, you know, it's  
5 a really interesting distinction because many  
6 people that argue, because we say end quality  
7 improvement it's an interesting lens through  
8 which to think of it. So for example we just  
9 had a very interesting discussion with our  
10 consensus standards approval committee about  
11 this issue of public reporting and  
12 understanding what we mean by quality  
13 improvement, for example.

14 And so as an example we would, for  
15 example, think of quality improvement measures  
16 that would be reasonable for NQF to consider  
17 things that would be reported to providers for  
18 feedback and use and benchmarking as opposed  
19 to many of the things we typically do in  
20 practice kind of back of the envelope, QI,  
21 keeping track of things.

22 Because again, there's a lens

1 there about reporting and benchmarking even if  
2 it is more internal initially.

3 DR. WINKLER: Just in terms of  
4 nomenclature, when measure developers submit  
5 measures for consideration by NQF, we actually  
6 ask them in its condition whether the measure  
7 was developed and intended for the, you know,  
8 public reporting as well as QI kind of element  
9 and if not, they really shouldn't be submitted  
10 if they're truly that lower level QI kind of  
11 measure.

12 And then from a nomenclature  
13 perspective, actually once even endorsed by  
14 NQF, they're known as voluntary consensus  
15 standards.

16 DR. LIEBERTHAL: Does NQF when  
17 they approve or accept a measure require that  
18 the measure has been tested in the real world  
19 to see if it is both valid and feasible?

20 DR. WINKLER: Well, that would be  
21 highly desirable, but it's been an interesting  
22 journey over the last few years. And several

1 years ago there was a big push to get a lot of  
2 measures out into the marketplace and a lot of  
3 need by a lot of users, particularly CMS and  
4 some of the other big payers.

5           And so NQF created a category, if  
6 you will, for measures that were otherwise met  
7 all the criteria with the exception of full  
8 field testing. And those measures could be  
9 granted a time limited endorsement. That is  
10 something that still exists, we're evaluating  
11 the utility of that.

12           It's been around now for about two  
13 years, those measures have an automatic review  
14 in two years to see and we're finding that a  
15 large number, not large, we don't know, but a  
16 significant number of them will either need to  
17 be abandoned or revised. So we are learning  
18 about this process.

19           Certainly I think it is most  
20 desirable that the measures have -- that we  
21 have -- it's hard to do a good evaluation if  
22 you don't have some information around how

1 they perform in the field, particularly  
2 outcome measures.

3           So while it's not absolutely  
4 required, it certainly is one of the  
5 evaluation criteria and I would expect that a  
6 measure that hasn't been field tested would be  
7 ranked fairly low on that aspect of the  
8 criteria.

9           DR. LIEBERTHAL: Has NQF or  
10 anybody set a methodology, a standard  
11 methodology for testing of measures?

12           DR. BURSTIN: NQF has a standard  
13 protocol that we require measure developers,  
14 who's measures come in as time limited to  
15 follow. So they get up to 24 months to submit  
16 their testing results.

17           We, for example, outline number of  
18 practices, the kind of reliability, validity  
19 testing we would require, that's really just  
20 getting to the point where we're starting to  
21 get feedback from the first set of measures  
22 that went through time limited.



1           It's clear that some of it's too  
2 stringent and some of them can't meet some of  
3 those. And the other interesting complexity  
4 as Reva mentioned all the work around health  
5 IT, is that we're currently at the point where  
6 many of our measures are now being, as we're  
7 calling them, retooled for use in electronic  
8 health records.

9           And testing in electronic health  
10 records is a whole different beast that we  
11 don't fully understand.

12           We've been having some of these  
13 discussions, so you might, for example,  
14 create, and this is what many of the HR  
15 vendors do, an idealized EHR test set that you  
16 would run the measure through to indicate how  
17 often you're getting the right number of  
18 people in the numerator, the right number of  
19 people in the denominator, but it doesn't  
20 answer issues about implementation in the real  
21 world.

22           Because as we know, that lovely

1 test set might not relate to some of the  
2 implementation challenges we face when EHR is  
3 going to practice. So this is definitely a  
4 moving target for us, but I think in this  
5 particular case, it seems unlikely that many  
6 of the outcome measures per se, would be  
7 untested.

8 I mean I think it's easier to make  
9 the case a process measure, a simple, you  
10 know, translation of a clinical guideline to  
11 a if then do something else. It's a little  
12 bit easier to imagine than something perhaps  
13 that requires adjustment or something like  
14 that coming forward and being untested.

15 DR. WINKLER: But an additional  
16 response to Allan's question is we do not have  
17 any established method of testing the  
18 questions on the evaluation and the submission  
19 to the measure developers is open-ended.

20 Has the measure been tested for  
21 reliability? How did you do it? What did you  
22 find? As opposed to as yet we haven't set

1 any, you have to do it this way or you have to  
2 do this particular type of testing. So it's  
3 an evaluation of the kind of testing that has  
4 been done.

5 DR. RAO: Question over here. How  
6 widespread are the measures used by non-CMS  
7 payers, what's been the uptake of the  
8 measures?

9 DR. WINKLER: I think it's  
10 variable. Certainly we know that there are  
11 measures used within health plans, certainly  
12 measures used within states. But actually  
13 it's a very hard thing for us to get a handle  
14 on to really know, because certain areas,  
15 organizations within Wisconsin, Minnesota,  
16 Massachusetts, some of those states all sorts  
17 of efforts around measurement.

18 So there's just lots happening and  
19 most of those usually are using our measures  
20 to a greater or lesser degree. But we don't  
21 always hear about everything that's going on.  
22 I mean I often get calls or e-mails from

1 hospitals saying, hey we're implementing all  
2 of your perinatal measures.

3           As a more common example, we have  
4 a question about, you know, this one. We have  
5 no way of really knowing that without those  
6 kind of random casual input. So I think it's  
7 greater than we even know.

8           DR. BURSTIN: And actually under  
9 our current HHS contract, which this is funded  
10 under as well, we're actually doing a formal  
11 evaluation assessment to begin to understand  
12 what measures have been taken up and actually  
13 why. I mean it would be helpful -- it's not  
14 just helpful to say who's using what, but why  
15 were those picked up and those not and why are  
16 some states still using a slight variation.

17           So this has been an interesting  
18 discussion actually, Marina had to just step  
19 out for her call, hopefully Charlie will join  
20 us soon. We did some work for the work around  
21 CHIPRA as they were kind of trying to figure  
22 out what those measures would be and I went

1 through our portfolio and pulled out all the  
2 child health measures.

3           And some of them were very  
4 hospital oriented or condition specific, but  
5 there's definitely a tension between what the  
6 state Medicaid programs for example, think  
7 they're -- think they can reasonable  
8 accomplish and obviously Lee can talk much  
9 more about this, versus perhaps some of the  
10 measures that we have.

11           So I think we're trying to begin  
12 to understand that. We're also hoping to  
13 build into our process going forward a really  
14 vigorous feedback loop so we can find out this  
15 measure works well, this measure doesn't  
16 really work well.

17           It may have been specified it  
18 worked well in an idealized environment but  
19 when it actually hits our hospitals, boy we're  
20 picking up lots of unintended patients being  
21 put through that particular lens.

22           DR. PERSAUD: I have two

1 questions, one does NQF have anything at all  
2 to do with process improvement methodology and  
3 do people -- do the users respond with these  
4 are unfunded mandates?

5 DR. BURSTIN: NQF has not  
6 traditionally been engaged in much of the  
7 process improvement work with the exception of  
8 our role as part of the National Priorities  
9 Partnership.

10 So what they're doing with those  
11 six national goals is they're to focus on six  
12 aims which includes quality improvement,  
13 payment, accreditation, the whole series of  
14 IT, a whole series of various drivers of which  
15 measurement, sort of our central focus, is  
16 only one sixth, one of the six drivers.

17 So certainly the NPP is trying to  
18 think through those process or improvement  
19 steps. And on the other side of this, you  
20 know, this is an interesting issue for us, we  
21 put forward what we think meets a criteria, as  
22 Reva will go over with you, but a fairly

1 stringent of measures that we think are  
2 appropriate to compare apples-to-apples.

3           That you're really getting a  
4 reasonable assessment of somebody's  
5 performance, allow end users to make better  
6 assessments, usable for people to make better  
7 decisions. But we're not the ones who  
8 necessarily at the end of the say, pick which  
9 measures get used.

10           So there's only, you know, to date  
11 a fairly limited role for us on the actual  
12 implementation side. Some of that may be  
13 evolving as health reform goes through or  
14 doesn't go through over the next couple of  
15 months, but it's still an open question for  
16 us.

17           DR. WINKLER: Well that what I was  
18 going to do is talk about the overall outcomes  
19 project, that this -- it's Charlie. But I  
20 think Marina would like to wait until she's  
21 back so she can hear your introductions, so  
22 we'll still continue on.

1                   Just to set the context, I  
2 mentioned that this is part of a large project  
3 funded by the Department of Health and Human  
4 Services. We do have the three outcomes  
5 steering committees. And so we will -- while  
6 they have there area focus, there's certainly  
7 areas of overlap.

8                   Within the condition specific  
9 areas that the main steering committee will  
10 look at one of the topics is asthma. Well,  
11 asthma certainly has a crossover for child  
12 health. So we will be bringing some of those  
13 measures both ways.

14                   Right now actually we're not  
15 finding a lot of asthma outcome measures, so  
16 that's a bit of a struggle. And we can talk  
17 about you know, perhaps are we looking under  
18 the wrong rocks.

19                   So I don't think it's really  
20 critical that a measure has to be in one  
21 versus the other. I mean we've got several  
22 avenues for some of those measures to be



1 evaluated and potentially recommended for  
2 endorsement. So we'll try to just stay as on  
3 top of the potential overlaps as possible.

4           We are focusing in on crosscutting  
5 measures as well as condition specific  
6 measures. So it isn't just particular disease  
7 states or particular conditions such as  
8 surgeries or whatever. So, I mean, we do want  
9 to look at things that are appropriate for all  
10 children or all patients, whatever is  
11 appropriate.

12           But today, as we've mentioned, we  
13 really don't have a lot of child health  
14 measures in general and very, very few outcome  
15 measures. I think at this point in terms of  
16 true outcome measures there's just two or  
17 three.

18           We do have an ongoing project that  
19 started earlier in the summer around pediatric  
20 cardiac surgery and there will be a group of  
21 measures, outcome measures coming forward from  
22 that. But again, a very narrow area that

1 important if that's your, you know, issue, but  
2 certainly does not address the vast majority  
3 of other issues that are appropriate for  
4 children.

5           And I think that's really the  
6 issue. We're going to talk about, a little  
7 bit more detail when Marina returns, about  
8 those real -- the measures that we have, but  
9 you're going to find that they really are  
10 very, very narrowly focused such that it only  
11 captures a tiny group of the entire child  
12 population.

13           So our goal with this project, to  
14 the degree we're able and those measures exist  
15 out there, is to expand NQFs current portfolio  
16 of child health outcome measures. But the  
17 focus is indeed on change order measures, so  
18 this project's all about outcomes.

19           And I think one of the interesting  
20 issues will be how do we want to define  
21 outcomes. What are outcomes for children?  
22 Where do we want to set the boundaries around

1 measures appropriate for, you know, public  
2 reporting, quality improvement within the  
3 health care system in terms of child health  
4 outcomes.

5           What are they? What do they look  
6 like? What do we -- what would we want in a  
7 perfect situation, even if they don't exist  
8 today. Go on the next. Okay.

9           Just to give you an overall view  
10 of the bigger project that you're involved in,  
11 this is laid out just strictly from a  
12 management perspective in phases; phase 1, 2  
13 and 3 and you're in phase 3 just because.

14           And this is where we've put these  
15 two areas that are rather specialized child  
16 health and mental health, they have their own  
17 steering committees. And so, anything that's  
18 labeled patient outcomes phase 3, that's you.

19           Phases 1 and 2 for just for  
20 interest we've sort of lumped all of the top  
21 20 condition into a topic areas that we're  
22 looking at. We're looking at respiratory

1 conditions, particularly asthma and COPD, also  
2 some intensive care unit measures,  
3 cardiovascular, this is where we've got all  
4 the measures, there are 19 candidate outcome  
5 measures for cardiovascular, so, you know, big  
6 area.

7           Metabolic, diabetes, chronic  
8 kidney disease, not a lot of measures but if  
9 you look at our existing portfolio we actually  
10 have a large number of outcome measures around  
11 diabetes already, not around chronic kidney  
12 disease but around diabetes.

13           Bone and joint, clearly cancer is  
14 important, GI/biliary ID and then eye care  
15 measures. So those are the topics this whole  
16 project and child health has its own special  
17 part of it.

18           That's why you're going to see  
19 from the NQF perspective staff wise, there's  
20 about -- there are five or six of us that are  
21 actually on this project staff doing various  
22 aspects of this project, so you may interact

1 with any of us at any given time.

2 DR. LIEBERTHAL: Quick question.

3 Asthma was included in the phase 1, and of  
4 those, asthma has both pediatric and adult  
5 components. I've been on three measures  
6 groups for asthma totally dominated by adult  
7 providers and allergists. Are we going to be  
8 dealing with asthma as a child health issue?

9 DR. WINKLER: I think we are. I  
10 think there's really only one measure that's  
11 coming through that we've identified so far.  
12 So I think in terms of this framework though  
13 for children, if we want to look at specific  
14 conditions that are appropriate, and asthma I  
15 think certainly would be on that list, we can  
16 look and see how best to keep the measures  
17 that appropriate for children in your purview.

18 DR. MCINERNEY: Similarly, mental  
19 health problems are one of the major areas now  
20 that we're dealing with in pediatrics and I'm  
21 wondering how are we going to interact with  
22 the mental health team, because, you know, how

1 we treat kids with ADHD and kids with  
2 depression and anxiety, et cetera that's  
3 critically important and we need some outcome  
4 measures for those conditions that are  
5 children specific.

6 DR. WINKLER: I think that at this  
7 point we're flexible and open. A lot of it  
8 will depend on the input we get from you and  
9 from the mental health steering committee,  
10 which is meeting next week, as well as what  
11 measures get submitted to us for  
12 consideration. And if necessary, we can bring  
13 the two of you together to talk about common  
14 issues if necessary, kind of depends.

15 At this point, right now there's a  
16 lot of unknowns in terms of what measures  
17 we're actually going to get in front of to  
18 deal with. And so it's great in the  
19 theoretical, but when we have the reality of  
20 what we're actually going to try and do, if  
21 necessary we can do a combined conference call  
22 and, you know, learn from each other.

1                   There's absolutely no reason we  
2   can't do that. So I think we need to wait to  
3   see what actually is going to get put in front  
4   of us to understand that, but sharing the work  
5   of the various committees where there's  
6   overlap I think is an important part because  
7   we really do want to foster the alignment, the  
8   harmonization, we don't want things going off  
9   in different directions without that.

10                   So that's going to be one, I  
11   think, the challenges for staff is to help you  
12   get there. Well, time for introductions?

13                   CO-CHAIR WEISS: So you have both  
14   of us here now and I think all of our other  
15   obligations have been discharged, right. So,  
16   depending upon how you look upon it, you're  
17   either fortunate that we'll be here for the  
18   remainder of the meeting or you're stuck with  
19   us. But in any event, Charlie Homer, have you  
20   introduced yourself?

21                   CO-CHAIR HOMER: I haven't. I  
22   know many of you, if not all. My name is

1 Charlie Homer, pediatrician day job, CEO of  
2 the National Initiative for Children's Health  
3 Care Quality and I've been privileged to sit  
4 on a number of the steering committees here,  
5 including the ambulatory steering committee  
6 and the hospital outcomes and efficiency  
7 steering committee.

8 DR. WINKLER: Charlie, and to all  
9 of you, as you're telling us a bit about  
10 yourself and your background in measurement,  
11 we also need you to mention if you have any  
12 involvement in measure development, any  
13 particular interest in these specific measures  
14 as a disclosure to the entire committee as  
15 well as for the record. So thanks for that.

16 CO-CHAIR HOMER: So in terms of  
17 the record on that, other than those  
18 committees, I do chair NCQAs Child Measurement  
19 Advisory Panel on the new set of measures that  
20 they're developing. Of course, I simply chair  
21 that I don't have any other NCQA position.

22 And NICHQ actually did bring the



1 BMI measure initially to NQF so I think  
2 somebody else may have taken over stewardship  
3 of that. But that's our only official measure  
4 steward job. We'll later on talk about the  
5 other project which NICHQ is doing jointly  
6 with NQF. So we'll cover that later.

7 CO-CHAIR WEISS: So do you want to  
8 go in that direction and wind up with me or do  
9 you want me to go ahead?

10 CO-CHAIR HOMER: No, of course.

11 CO-CHAIR WEISS: All right. Well  
12 I'm Marina Weiss and I'm with the March of  
13 Dimes and have been for a number of years.  
14 And before that worked as an appointee in the  
15 Clinton Administration, and before that was on  
16 Capitol Hill, and before that was an academic.

17 So my passion, my greatest area of  
18 interest is maternal and child health. I was  
19 founding board member of NQF and have rotated  
20 off the board some years ago, but continue to  
21 be very interested in the quality agenda and  
22 quality improvement as well as safety and

1 such.

2           And so was instrumental in  
3 bringing my own organization into a steering  
4 committee that led about 70 organizations here  
5 in town and around the country and working  
6 together with NACHRI and some others to build  
7 a very robust quality section that, as I  
8 described earlier, was included in the most  
9 recent re-authorization of the Children's  
10 Health Insurance Program and extends to  
11 Medicaid as well as the CHIP program.

12           I don't know if any conflicts of  
13 interest at all. This is just an area in  
14 which the March of Dimes is now deeply  
15 involved because of our interest in quality  
16 improvement and safety. And so that's it.

17           MS. MARINELARENA: Hi my name is  
18 Melissa Marinelarena and I'm the Project  
19 Manager on the child health project. And  
20 you'll see my name floating around with the  
21 other outcome projects as well. I want to  
22 thank you all for coming here and you'll be

1 hearing a lot from me. So thank you very  
2 much.

3 DR. WINKLER: I'm Reva Winkler.  
4 I'm a project consultant to NQF now for the  
5 last nine years. I'm an obstetrician  
6 gynecologist by training and 20 years of  
7 practice experience before coming to NQF nine  
8 years ago.

9 I've been Project Manager for many  
10 of the efforts that NQF has done particularly  
11 around ambulatory care and consult on a lot of  
12 our perinatal work as well. I'm overseeing  
13 all of the outcomes work for the entire HHS  
14 outcomes contract.

15 MS. MORSELL Hello, my name's  
16 Ashley Morsell. I'm a Research Analyst and I  
17 support Reva and Melissa with this project and  
18 I was the one sending all the e-mails trying  
19 to get everyone here. So I thank everyone for  
20 coming and for your cooperation.

21 DR. MCINERNY: Hi, I'm Tom  
22 McInerny from Rochester, New York and I blame

1 Charlie for getting to this position here.  
2 Way back, I forget how many years ago, we did  
3 HIPPO, not HIPAA, but HIPPO, H-I-P-P-O,  
4 Helping Improve Pediatric Patient Outcomes, an  
5 interesting project that Charlie ran through  
6 NICHQ with collaboratives and our practice.

7 I really started as a primary care  
8 pediatrician and continued to be a primary  
9 care pediatrician, but I moved over to  
10 academia about 11 years ago. But our project  
11 was a great project on improving how we  
12 provided care for children with asthma and we  
13 really did I think have some good outcomes  
14 from that, we're still using a lot of that.

15 Then we did another project on  
16 ADHD some years later, which I think worked  
17 out well. And in my work now as Associate  
18 Chair for Clinical Affairs in the Department  
19 of Pediatrics working hard to make sure that  
20 our inpatient and outpatient care at our  
21 children's hospital is doing a lot of quality  
22 improvement activities and we're making some

1 good progress there.

2           And I now have been on the  
3 steering committee for quality improvement for  
4 about three years and learning a lot there,  
5 working with a lot of good folks. And Allan's  
6 going to be joining us, which will be great.  
7 He's actually on the committee already, but  
8 our first meeting will be next month.

9           I don't really have any conflicts  
10 of interest other than the steering committee  
11 on quality improvement. In that sum, there  
12 are people like Allan and other people on the  
13 steering committee as sort of a subcommittee  
14 they're doing some measures development. But  
15 I'm personally not involved in that aspect of  
16 it.

17           DR. RAO: Hi I'm Goutham Rao, I'm  
18 at the University of Pittsburgh where I run  
19 the pediatric obesity center and have done  
20 that for about five years. Also teach  
21 clinical epidemiology and biostatistics at  
22 Pitt Medical School.

1           This is my first NQF meeting and I  
2 think I have to thank Charlie as well for  
3 getting me here at some point. I don't have  
4 any conflicts of interest.

5           I had served on an American Board  
6 of Medical Specialties Quality Improvement  
7 Committee around GERD and hiatal hernia, but  
8 they're not very active right now; and a prior  
9 committee similar to that from the American  
10 Medical Association in about 2002, 2003.

11           So those are my connections to  
12 quality improvement. Looking forward to this  
13 meeting very much. Thanks.

14           DR. JENKINS: Hi everyone. I am  
15 Kathy Jenkins. I'm from the Children's  
16 Hospital in Boston. I am a cardiologist. I  
17 actually have a history of doing measurement  
18 development in the field of pediatric  
19 cardiology and have developed a number of  
20 measures.

21           In that regard, I am currently the  
22 chair of the American College of Cardiology

1 Quality Metric Workgroup, which is actively  
2 involved in doing quality metric development  
3 across the breadth of pediatric cardiology  
4 practice.

5           And I do sit on the American  
6 College of Cardiology American Heart  
7 Association combined performance metric  
8 taskforce. I do have one measure related to  
9 cardiac surgical mortality that was -- my  
10 methodology was partially incorporated into  
11 the PDI 6 measure that was put forward and  
12 approved by AHRQ I think last year or the year  
13 before.

14           And I am a measurement developer  
15 for one of the measures that the Children's  
16 Hospital Boston put forward as part of the  
17 pediatric cardiac surgical program that was  
18 discussed previously, though it's slightly  
19 different than the AHRQ methodology.

20           In addition, I am the Chief -- as  
21 Safety and Quality Officer for Children's  
22 Hospital Boston and I've been in that position

1 for the last five and we have done a lot of  
2 measurement development for internal  
3 benchmarking in that role for internal  
4 purposes within the hospital and have been end  
5 users to all -- in the pay for performance and  
6 Medicaid pay for performance work in  
7 Massachusetts, which is a front runner state  
8 in this regard.

9           So I've both been at the front end  
10 of measurement development and at the back end  
11 of measurement use in all of my various roles.

12           DR. SCHWALENSTOCKER: Good  
13 morning, my name is Ellen Schwalenstocker and  
14 I'm acting Vice President of Quality Advocacy  
15 and Measurement for the National Association  
16 of Children's Hospitals and Related  
17 Institutions otherwise known as NACHRI.

18           NACHRI is a not for profit  
19 membership organization similar as Reva was  
20 describing NQF, I'm like sort of the words we  
21 use to describe NACHRI. About 200, a little  
22 over 200 children's hospitals both



1 freestanding children's hospitals as well as  
2 children's hospitals that are parts of larger  
3 systems as well as a third group of pediatric  
4 specialty hospitals, primarily rehab.

5 I also am a liaison to the  
6 committee from NACHRI that Tom described, the  
7 steering committee on quality improvement and  
8 management of the American Academy of  
9 Pediatrics from NACHRI.

10 NACHRI has a number of data  
11 programs that Case Mix Program, for example,  
12 pulls administrative data and therefore serves  
13 as a measure provider, if you will, for  
14 several of the Joint Commission ORYX measures  
15 in terms of potential conflicts of interest.

16 We also have a system called the  
17 Virtual Pediatric Intensive Care System which  
18 -- through which in collaboration with a  
19 couple of other organizations, including the  
20 Child Health Corporation of America, we  
21 identified a set of initial pediatric critical  
22 care measures that have been endorsed by NQF,

1 a couple of which would probably fall in the  
2 outcomes measure category.

3 DR. CLARKE: I'm David Clarke from  
4 Denver, Colorado and I practiced congenital  
5 heart surgery for 30 years and then about five  
6 years ago I discontinued clinical practice,  
7 but continued with my interest in outcome  
8 evaluation.

9 In the early 2000s after pediatric  
10 cardiac surgery finally had a standardized  
11 nomenclature between Europe and North America.  
12 I was involved in the development of a  
13 complexity score which in with the lack of  
14 data was developed by consensus of about 50  
15 surgeons, and this is related to cardiac  
16 surgery procedures in the Quality Aristotle  
17 Complexity Score.

18 It was in response to the trend  
19 that was starting around that same time of  
20 evaluating pediatric cardiac surgery based on  
21 raw outcome data primarily raw mortality data.

22 And so basically what was

1 happening is the largest centers that dealt  
2 with the most complex disease were getting a  
3 bad rap and were having trouble competing and  
4 therefore were reluctant to share their data  
5 and was snowballing the wrong way.

6           And so as a result of this and  
7 also in combination with the RAC Score out of  
8 Boston, the STS database began to accumulate  
9 data along with the European Association for  
10 Thoracic Surgery database and the risk  
11 adjustment for mortality and the Aristotle  
12 Complexity Scores were applied to the analysis  
13 for that data so that we finally got at least  
14 some risk adjustment into pediatric  
15 cardiothoracic surgery.

16           So at this point in time it's  
17 okay. It's not perfect, but it's okay. We're  
18 in the process of trying to validate the  
19 Aristotle Score based on actual outcomes and  
20 we have completed the evaluation of the  
21 mortality score using approximately 80,000  
22 patients from the European and the Society of

1 Thoracical Surgical Database and that should  
2 be published any day now in the Journal of  
3 Thoracic and Cardiovascular Surgery.

4           So from that standpoint I guess I  
5 do have a conflict, although I have to add  
6 that the conflict is definitely not financial.  
7 I work on the Aristotle Score and its  
8 maintenance on a voluntary basis.

9           I also have been fairly involved  
10 with the STS congenital database. I serve on  
11 the database committee and am the Chairman of  
12 what's called the data verification  
13 subcommittee, which is responsible for  
14 performing randomized audits of five centers  
15 around the United States that are participants  
16 with the STS database every year.

17           And at this point, we've been  
18 doing that for three years and have completed  
19 15 data audits and have found that for the  
20 most part the data is very accurate but there  
21 are some problems areas in terms of the  
22 difficulty collecting certain data fields.

1                   I also do some institutional  
2 review board work, so I'm involved in human  
3 research on that end as well. And I think  
4 that's about it. This is my first meeting for  
5 NQF.

6                   DR. PERSAUD: Good morning, I'm  
7 Donna Persaud and I guess I would be regarded  
8 as one of the end users of all this work that  
9 we're going to do and that I am the Chief of  
10 Pediatrics for a large safety net  
11 organization, it's Parkland Health and  
12 Hospital Systems community oriented primary  
13 care clinics.

14                   We have 11 clinics, we have 11  
15 school based clinics in addition and we do  
16 juvenile justice care as well as homeless  
17 outreach and refuge. So we are a large  
18 Medicaid practice. We do about 150,000  
19 provider visits a year and about half a  
20 million immunizations.

21                   We have just installed EPIC and so  
22 I am heavily involved in that development. We

1 actually developed it -- we did not use EPICs  
2 model system, we built it from ground up and  
3 I think one of the most interesting things  
4 that we did that I shared at the group here is  
5 that we separated out the ages very discretely  
6 for health maintenance exams.

7           Whereas people often range those  
8 ages, we separated out the 2, 4, 6, 9, 12 and  
9 I think that that has given us incisive  
10 ability to respond rapidly to changes in what  
11 should be done at different ages.

12           What we're doing right now is  
13 trying to extract data from the system to help  
14 us understand how we're using it and whether  
15 we're promoting outcome. And I think that  
16 EPIC was unprepared for the level and our IT  
17 staff were unprepared for what we would want  
18 to get from the system.

19           I just came in from Intermountain,  
20 from Brent James Quality Training Program, we  
21 just did our presentation, it was -- my  
22 project was with the correctional facility

1 actually on decreasing wait times between when  
2 inmates complained of toothache to when they  
3 got into the dental care for definitive  
4 intervention.

5           And we actually demonstrated  
6 results and so I've got a lot in my mind. I  
7 think this is exciting and interesting. I  
8 have no prior involvement in formal setting of  
9 measures, although it is a high interest of my  
10 system.

11           We're looking at both individuals  
12 and moving the populations in an urban  
13 environment towards health. And we're trying  
14 to think beyond just traditional straight  
15 primary health care and we think the children,  
16 especially with the obesity epidemic, are in  
17 such need under other models of care that can  
18 move the population towards wellness faster,  
19 because we're concerned that getting every  
20 child in for primary care visit on schedule  
21 might not practically be able to do that.

22           So thank you for the opportunity.

1 How did I end up here, someone from Parkland  
2 saw the request, the CMO called me, my CV was  
3 sent and that was it.

4 DR. ZIMA: And I'm Bonnie Zima and  
5 I think I'm the only child psychiatrist here  
6 on the committee. And so I was really  
7 interested in your question and I'm very much  
8 wondering whether there's a child psychiatrist  
9 on the mental health committee as a buddy.

10 DR. PERSAUD: More than one  
11 hopefully.

12 DR. ZIMA: Is there a child  
13 psychiatrist on the mental health committee?

14 DR. WINKLER: I'll have to double  
15 check. I'll get the roster for you.

16 DR. ZIMA: Okay. And the way I  
17 came on this was actually I was on the APAs,  
18 the American Psychiatric Association's  
19 committee on quality indicators and their  
20 Chair saw the announcement and then also Larry  
21 Greenhill at Columbia, who is the President of  
22 the American Academy of Child Psychiatry also



1 supported my nomination.

2           So I think we're clearly in the  
3 infancy of developing quality indicators. I  
4 have no conflicts of interest. I'm proud to  
5 say I've never taken any pharmaceutical  
6 industry support for any of my research.

7           I've been funded predominately by  
8 the NIMH as well as the state of California  
9 through contracts. I'm not only a child  
10 psychiatrist, but a health services researcher  
11 and my main role at UCLA is really Associate  
12 Director now of the Health Services Research  
13 Center.

14           I'm not Associate Director of the  
15 whole department as stated in the materials  
16 and I don't think I want to be. And my  
17 introduction to quality of care was really an  
18 opportunity that was really I think kind of  
19 groundbreaking and that was several years ago  
20 Dr. Steve Mayberg who is the Director of our  
21 state department of mental health had some  
22 left over money and to the tune of \$1.5

1 million.

2           And he turned to the universities  
3 of California and said what can you tell me  
4 about the quality of care for children in the  
5 public mental health system and can you do  
6 this in two years.

7           So it was really amazing because  
8 we developed a collaborative infrastructure  
9 pretty quickly across five universities within  
10 California, developed this strategy, developed  
11 121 quality indicators for the assessment and  
12 treatment of ADHD, major depression, conduct  
13 disorder, applied it to a statewide sample of  
14 children in 22 clinics in 58 counties and used  
15 the episodic care methodology.

16           So what did we find? We actually  
17 found very similar to Beth McGlynn's work and  
18 as well as Rita Mangione-Smith's work that  
19 only about half the kids had any sort of  
20 acceptable quality.

21           We also asked the question did it  
22 vary by race, ethnicity, gender, things like

1 that. The answer was no. If the kid got into  
2 care and stayed into care for at least three  
3 visits, there was no variation. There was  
4 also big issue, and I think this gets back to  
5 the whole issue of understudied kids in  
6 Medicaid.

7 In the state of California what  
8 happens is that each county can decide whether  
9 they're going to use their Medicaid money to  
10 fund directly operated clinics or contract  
11 out. So one of the big issues on a policy  
12 level was where does quality care vary, was it  
13 better to have it in a directly operated  
14 clinical or contracted out clinic.

15 And the bottom line was we  
16 couldn't pick up any difference. So all of  
17 this work then led to an R01 that we have some  
18 findings that are going to go under review  
19 next month asking the question of quality of  
20 care for ADHD in managed care Medicaid program  
21 in Los Angeles.

22 And what's important about that is

1 I think it's the first study looking at  
2 quality and primary care and specialty mental  
3 health, okay. And right now we also have an  
4 R34 looking at development of a web-based  
5 clinician decision support tool to do a better  
6 job engaging parents in the process of  
7 medication treatment decisions.

8           It's a very sensitive issue when  
9 you're using psychiatric meds and also again,  
10 seeing whether we can improve safety and  
11 appropriateness in medication. And again this  
12 is all focused on Medicaid funded programs.  
13 So I think that's it.

14           MS. PARTRIDGE: I'm Lee Partridge.  
15 I'm the Senior Health Policy Advisor with the  
16 National Partnership for Women and Families,  
17 which is an old consumer advocacy  
18 organization, particularly concerned about  
19 health care and job working environments,  
20 health care benefits, harassment, et cetera.

21           We started out as the Women's  
22 Legal Defense Fund back in the Civil Rights

1 days to work particularly on that last issue,  
2 workplace issue, but over the years we have  
3 more into a very, very deeply involved  
4 organization around health care quality  
5 particularly in respect to women and families  
6 and in my case, very definitely woman and  
7 families of lower income.

8           Because I came to the partnership  
9 from 25 years in the world of Medicaid and I  
10 do remember Dr. Mayberg, you were very  
11 fortunate to have him in California. I was  
12 the Medicaid director here in the District of  
13 Columbia from 1983 to 1992.

14           We are a medically rich, a very  
15 medically rich community with a major  
16 children's hospital. The population I served  
17 was heavily Hispanic and African American and  
18 of course, very interesting differences in the  
19 pediatric quality of care for those children,  
20 I might say Hispanic and African American.

21           I then went on and worked with the  
22 National Association of State Medicaid

1 Directors for 10 years and was part of the  
2 founding board, as a purchaser as a matter of  
3 fact, as an alternate member of the founding  
4 board of NQF.

5 I have been working with NQF now  
6 as long as Reva has. I co-chaired the very  
7 first nursing home standards committee which  
8 was an education for all of us I think. And  
9 I have been most recently a member of the  
10 perinatal measures committee, which reported  
11 measures out last winter.

12 I don't believe I have any  
13 conflict of interest financially. I should  
14 share the fact that I too am in the NCQA Child  
15 Health Steering Committee and I am currently  
16 chairing the Medicare Health Plans  
17 Accreditation Committee for NCQA.

18 And we, of course, looking at both  
19 the current standards for health plans that  
20 participate in the Medicaid program as well as  
21 the clinical measures that are being used in  
22 the accreditation of those programs.

1 DR. DOCHERTY: Hello I'm Sharon  
2 Docherty. I'm an Associate Professor at the  
3 Duke University School of Nursing where I  
4 direct the pediatric acute and chronic care  
5 nurse practitioner program. I spend the  
6 majority of my time conducting research.

7 I have several NIH funded studies  
8 centering around issues related to the quality  
9 of life of infants and children undergoing  
10 life sustaining treatments for life  
11 threatening illnesses.

12 Our most recent award is that we  
13 have a five year study we're looking at  
14 decision making with providers and parents of  
15 infants born with life threatening illnesses.

16 I practice as a pediatric nurse  
17 practitioner in the Duke Children's Hospital  
18 mainly with chronically ill children and I am  
19 here representing the National Association of  
20 Pediatric Nurse Practitioners.

21 And I don't have any conflict of  
22 interest. The only thing I can think of is

1 I'm working on a measure right now to measure  
2 technology dependence in some of the children  
3 that we're studying. I'm happy to be here.

4 DR. LIEBERTHAL: I'm Allan  
5 Lieberthal. I'm a primary care pediatrician  
6 and clinical pediatric pulmonologist at Kaiser  
7 Permanente in Panorama City, California, which  
8 is in the San Fernando Valley about 10 miles  
9 north and one hour during rush hour away from  
10 UCLA where Bonnie is.

11 I'm the new member of the AAP  
12 steering committee on quality improvement and  
13 management and was nominated by the AAP. I've  
14 also been on the measurement interest group  
15 subcommittee of that committee for several  
16 years.

17 I was co-chair of the PCPI  
18 committee that wrote the acute otitis externa  
19 and OME measures and I've been working with  
20 Carole Lannon studying the utility of those  
21 measures, a study that's nearly complete.

22 I'm also involved in evidence-



1 based medicine, I was the co-chair of the  
2 original acute otitis media guideline  
3 committee for the AAP and now I'm chairing the  
4 revision of that guideline committee and I  
5 also chaired the AAPs bronchiolitis guideline  
6 committee. So I have been involved in quality  
7 -- measurement work.

8 I've also been a member of the  
9 NCQA asthma measures committee and those  
10 measures are now available for public review.  
11 And I'm sitting on a Robert Wood Johnson  
12 Foundation panel that's looking at asthma  
13 measures and their application for attribution  
14 of costs, and that's an ongoing committee. I  
15 have no financial conflicts.

16 DR. BURSTIN: What a great  
17 committee. I'm Helen Burstin again, I'm the  
18 Senior Vice President for Performance Measures  
19 at NQF. I oversee all of our work related to  
20 practices, measures, frameworks as the case  
21 may be.

22 I'm coming up on my three-year

1 anniversary at NQF actually in January. I  
2 feel like I still just arrived. Before that  
3 I was at AHRQ for seven years where I directed  
4 the Center for Primary Care and Prevention in  
5 Clinical Partnerships, oversaw the work of  
6 U.S. Preventive Services Taskforce.

7 I'm an internist by training and I  
8 still see patients on Friday mornings at a  
9 Latino health center here in town.

10 DR. MCINERNEY: Allan reminded me I  
11 am an AAP representative to the AMA PCPI and  
12 I have attended those meetings fairly  
13 regularly. I've been a little disappointed  
14 that with just a few, only a few measures that  
15 they've really considered have applied to  
16 children. Of course they're largely looking  
17 at adult measures. So I'm glad that we have  
18 this group.

19 And I wanted to ask a question  
20 because I know that the Chair of the Steering  
21 Committee on Quality Improvement, Javier  
22 Sevilla has sat on the AHRQ CHIPRA committee

1 that developed through a Delphi process.

2           They came up with I think 25  
3 measures and I'm trying to figure out how is  
4 that going to harmonize with the measures that  
5 we're going to be talking about, because they  
6 went through quite a bit of work, I think to  
7 do that.

8           CO-CHAIR WEISS: Right. That is  
9 the group that I spoke about earlier and the  
10 task was to get a set of recommendations  
11 together for the Secretary's consideration in  
12 meeting the requirements of the Children's  
13 Health Insurance Re-authorization section on  
14 quality.

15           That deliberation is currently  
16 underway as I understand it, at HHS and they  
17 are under obligation, the law calls for them  
18 to publish the first core set at the beginning  
19 of the month of January of 2010.

20           But one of -- I also sat on that  
21 committee with Javier and one of the things  
22 that we did was to tier our recommendations.

1           And yes there was a set of 25 very  
2 specific performance measures that we put on  
3 the table, but we also hope we signaled to the  
4 community at large that there were other areas  
5 that we felt merited further consideration and  
6 additional work.

7           And that is wave 1 or phase 1 of  
8 what we hope is a more comprehensive process  
9 in looking measures. The emphasis in that  
10 core set was on what's out there right now  
11 ready to go and where are these measures  
12 currently being used at the state level in the  
13 Medicaid and CHIP programs and therefore  
14 recognizing that that time frame is pretty  
15 short, could we get these performance measures  
16 up and operational in more venues across the  
17 country very quickly.

18           So that was the emphasis there.  
19 So what we do here should feed into the next  
20 phases of that larger project.

21           CO-CHAIR HOMER: Is there anyone  
22 on the phone?

1 MS. PERKINS: I'm Jane Perkins,  
2 I'm here.

3 CO-CHAIR HOMER: Would you like to  
4 introduce yourself please?

5 MS. PERKINS: Sure. I'm the legal  
6 director at the National Health Law Program.  
7 Most of my work here over the last 25 years  
8 has focused on the Medicaid program, in  
9 particular EPSDT. I've done writing on this  
10 and engaged in policy and litigation on the  
11 EPSDT program.

12 I came to quality measures and  
13 I've sort of darted in and out of them over  
14 this period of time. But particularly in the  
15 late 1990s when I was on a working group that  
16 HCFA and the National Academy for State Health  
17 Policy sponsored on QZMC \*\*\*11:29:47.

18 Then in the early 2000s I was on a  
19 steering committee that was looking at  
20 external quality review organizations and  
21 their role in improving quality and was sort  
22 of the take away from there was just how few

1 efforts are being aimed at children in the  
2 Medicaid programs by the volume of children in  
3 the Medicaid program.

4           We have over the years included  
5 and tried to aggressively include performance  
6 measures in the litigation that we have won  
7 and have, whether it be measure of lead  
8 testing or Body Mass Index and have tried to  
9 have measures that would apply not only in  
10 cases where we've been trying to get  
11 preventive and screening part of EPSDT  
12 working, but also the treatment part of EPSDT  
13 working and with a particular focus on  
14 children with special health care needs.

15           Obviously, as you all know, it can  
16 be getting something on the piece of paper is  
17 so very difficult and then having all of the  
18 different managed care companies using their  
19 own computers that measure things differently  
20 can be just a screaming headache.

21           So I was very drawn by your  
22 comments earlier as you're giving your

1 presentation about harmonizing and making  
2 these measures ones that will be -- have  
3 somehow a maximized value to providers so that  
4 they will use them and want to use them. And  
5 that's it.

6 CO-CHAIR HOMER: Thank you Jane.

7 DR. WINKLER: Anybody else?

8 MS. PERKINS: I appreciate your  
9 having me on the phone by the way. I really  
10 appreciate this accommodation.

11 DR. WINKLER: Thank you Jane. Is  
12 there anybody else on the phone? We weren't  
13 sure who else might be calling in.

14 CO-CHAIR HOMER: Did we want  
15 members of the audience?

16 DR. ZELL: I'm Bonnie Zell. I'm  
17 Senior Director for Population Health at NQF.

18 MR. CORBRIDGE: Good morning  
19 everyone, my name is Ian Corbridge. I'm, I  
20 guess, Project Manager for the mental health  
21 project. I'm just sitting on today kind of  
22 seeing discussion, it also sounds like there

1 might kind of be some collaboration that we  
2 need to do with this group as well as the  
3 mental health group.

4 So anything that we can do to help  
5 facilitate that, that's what we're here for.  
6 So thank you very much and have a good day.

7 CO-CHAIR HOMER: Terrific. Thank  
8 you. Well, it looks like we're actually quite  
9 -- are we -- well -- Reva, have you not  
10 finished?

11 DR. WINKLER: No.

12 CO-CHAIR HOMER: Oh, okay I'm  
13 sorry. I thought you -- I heard such a  
14 wonderful project overview when I was walking  
15 in. So let us return to the project overview.

16 DR. WINKLER: Thank you, now that  
17 we all know each other. I asked Melissa to  
18 put this slide up. You should all have this  
19 in your materials and these are the outcome  
20 measures that have been endorsed by NQF.

21 And this is where I'm going to ask  
22 you to start thinking because I think if you



1 look at this, and there were more than I  
2 realized, somebody counted them and said there  
3 were 25 of them, but I think if you take a  
4 look at them, you'll see that they really  
5 don't have a whole lot of rhyme or reason as  
6 an organizational group.

7           They kind of came to us in  
8 multiple projects, you know, a couple here and  
9 a couple there and a couple here and there and  
10 here was what we got. And so at the end of  
11 the day, it isn't a very cohesive set of  
12 measures.

13           And one of the things, even though  
14 they're all outcome measures, important,  
15 address very important issues, one of the  
16 things that we really would need your help on  
17 is understanding how do we figure out where  
18 these fit in and what are the ones we don't  
19 have that we truly need.

20           In other words, sort of the  
21 organizational structure, the framework, how  
22 are we going to describe child health outcomes

1 in a way that allows us to plug these in,  
2 these measures in to whatever spot they belong  
3 in and then say, hmm, here are the empty  
4 spots.

5           And we either need to find  
6 existing measures if they exist or, you know,  
7 really try and promote the measure development  
8 so that we plug the holes so that at the end  
9 of the day, rather than having a mish-mash of  
10 this, like we do now, we are working towards  
11 a coherent organization of outcome measures  
12 that meets a variety of needs.

13           So we need to understand what the  
14 dimensions are, we need to understand what  
15 those domains should be and, you know, whether  
16 it's a two dimensional grid or if it's several  
17 two dimensional grids that you slice and dice  
18 the issues in a variety of ways, great.

19           That's really one of the biggest  
20 things you can help us with understanding for  
21 this project. It will drive both our call for  
22 measures and it will drive our analysis on

1 measures that we need but don't yet have.

2           So keep in mind as we start  
3 talking about things, how might we figure out  
4 what that sort of big thing looks like that we  
5 can plug the measures into and then figure out  
6 where the holes are. So that's kind of what  
7 we're working on today. So this should be a  
8 reference, and questions at all times.

9           DR. MCINERNY: I'm going to share  
10 my primary care bias. Although certainly  
11 measures for children that are hospitalized  
12 are important and they often are expensive in  
13 terms of their morbidity, mortality and  
14 dollars.

15           We have to keep in mind that a  
16 very, very small fraction of children end up  
17 in the hospital at any given time or during  
18 their lifetime for that matter and that I  
19 think most of us would agree that it's the  
20 outpatient care for children that's so  
21 critically important and how we provide that  
22 care for children, the quality of care we

1 provide for them can dramatically improve  
2 outcomes, their health outcomes.

3           And so my plea would be that, you  
4 know, we look and maybe perhaps slice and dice  
5 you talk about outpatient outcomes, very  
6 important and try and get a significant number  
7 of those that we can agree on and, you know,  
8 we can do some of the inpatient outcomes, but  
9 the numbers are so small that you're not going  
10 to affect the vast majority of children with  
11 inpatient measures.

12           DR. WINKLER: I think one of the  
13 things that's very clear when you look at the  
14 list is the focus is primarily on hospitalized  
15 measures and there are measures for  
16 hospitalized patients.

17           And so the fact that there are  
18 likely to be others outcomes of interest when  
19 you're looking at children as their entire  
20 population, again, is what you need you to  
21 help us, how do we describe that, how do we  
22 portray that, how do we understand so that we

1 can just say oh we need more patients for, you  
2 know, outcome measures for outpatient care.

3 That's probably a little too  
4 vague. We need to be a little bit more --  
5 have a better understanding of what those  
6 might look like and the various types of  
7 outcomes.

8 And we've got some ideas to just  
9 offer to you as a place to start, but we're  
10 hoping this afternoon this will be a  
11 discussion that you'll entertain.

12 And we can do some serious  
13 thinking around how do you want to organize  
14 this so that we can at the end of the day be  
15 able to convey this information to others and  
16 get the outcome for the project that we're  
17 looking for as well as improved outcomes for  
18 kids. Any other questions?

19 DR. JENKINS: Well just in terms  
20 of brainworks, although I think to your point  
21 about ambulatory measures, the scope and locus  
22 could be very different. We sort of went

1 through this exercise five years ago for  
2 Children's Hospital Boston and ended up  
3 choosing the Institute of Medicine STEEF  
4 criteria as our overall framework and I must  
5 say having watched it evolve over five years  
6 it's worked awfully low.

7           So I would just offer that up and  
8 could show what, you know, how that kind of  
9 looked and how a lot of the ornaments hung  
10 very nicely under that tree, so.

11           CO-CHAIR HOMER: I have a  
12 technical comment, which is I think the  
13 pediatric diagnosis column in here must be  
14 pulling from some other peculiar database  
15 because it's irrelevant. So in the next  
16 version of this just get rid of that field  
17 it's random.

18           MR. CORBRIDGE: I have a comment  
19 for that, somehow when we were clearing the  
20 fields it seems to be sorting alphabetically  
21 instead of by the outcomes or process. So I  
22 do apologize for that and we'll try to get it

1 squared up. Sometimes when you're working  
2 with Excel it doesn't always do what you want,  
3 so.

4 MS. PERKINS: This is Jane on the  
5 phone, I'm sort of going through the slides  
6 looking for the list of them and I'm having  
7 trouble coming up with it. Let me just ask a  
8 quick question and that is, are all of these  
9 measures outcome oriented as opposed to  
10 process oriented?

11 DR. WINKLER: Yes, Jane, I'm  
12 sorry. We flipped over to the bundle of  
13 materials that was sent to you as the large  
14 PDF and it begins on page 10. And yes indeed,  
15 this list is all outcome measures  
16 intentionally.

17 There is an additional list of the  
18 process measures just for completeness, but it  
19 starts out with all of the outcome measures.  
20 So you do have that in the large PDF bundle of  
21 information that was sent out to you.

22 MS. PERKINS: And will we -- so is

1 this group to focus on both or just the  
2 outcome?

3 DR. WINKLER: This is all about  
4 outcomes.

5 MS. PERKINS: Okay.

6 DR. WINKLER: Okay. So Melissa  
7 you can go back to the slides now. Jane we're  
8 going to go back to the slides and I'll start  
9 with slide number 25.

10 MS. PERKINS: Okay. Yes.

11 DR. WINKLER: I'll try and stay as  
12 oriented there. So, we did mention that there  
13 are some measures around pediatric cardiac  
14 surgery, again another hospitalized narrow  
15 condition area that are in the pipeline.

16 So the actual number of outcome  
17 measures will change in another couple of  
18 months. They are going through the consensus  
19 process which we will talk about. Next slide.

20 But essentially, you know, NQF has  
21 experienced the challenges around measuring  
22 for child health. The emphasis on most of the



1 existing measures out there are for adults and  
2 particularly older adults.

3           Certainly the funders of our  
4 projects have been those who deal with older  
5 adults, we've done a lot of work for CMS and  
6 so you kind of get the expected results.

7           So the children -- measures for  
8 children do represent, you know, a relatively  
9 small group of all of our endorsed measures,  
10 but we do have some issues around measurement  
11 for children that we have to sort through.

12           One is inconsistent definition of  
13 children. You know, what's a kid? Age  
14 inclusion. Sometimes it's appropriate for the  
15 condition, but sometimes it's just an  
16 arbitrary, you know, definition and that does  
17 make it hard for the set to have any kind of  
18 cohesion to it.

19           Inconsistent application of  
20 crosscutting measures. There are a lot of  
21 measures that are created that really aren't  
22 specific to any particular patient group. But

1 because they were developed by organizations  
2 that only look at adults, things like  
3 medication reconciliation, they specify it  
4 only for adults.

5           And so there's no reason it can't  
6 be applied to children, but they just don't do  
7 it. So these are some of the issues that have  
8 made it hard so that there could potentially  
9 be more measures appropriate for children, but  
10 for whatever reason kids just don't get added  
11 to the mix.

12           So also in terms of outcome  
13 measures, overall outcomes is sort of the  
14 later measures in development. We're starting  
15 to see an upswing in them, but like  
16 everything, you know, children, measures for  
17 children fall even further behind.

18           So, you know, these are the  
19 struggles and challenges, but I think that we  
20 should be able to -- we've already identified,  
21 you know, a group of measures, we should  
22 certainly be able to hopefully identify a few

1 more and certainly identify the measures we  
2 want to have in fairly specific detail.

3           Not just we want measures, but  
4 what kinds of measures, what should they look  
5 like, what should they about so that we could  
6 take those to the measure development  
7 community and really get some traction on  
8 getting those measures developed. So that is  
9 a huge goal for this project as well.

10           So let's just look at the measures  
11 we've endorsed for children, and again, most  
12 of these are around processes. And you can  
13 see that they tend to be some prevention and  
14 immunization, but it's mostly the immunization  
15 measure.

16           Some patient experience with care  
17 measures, actually there are three or four  
18 that are appropriate for children and  
19 particularly around adolescents.

20           Within our perinatal set of  
21 measures, some of them very specifically  
22 target the neonate or the aspects of pregnancy

1 such as, you know, elective delivery before 39  
2 weeks, but yes it's perinatal, but the major  
3 impact is on the newborn.

4           We certainly have outpatient  
5 measures in certain condition areas. And  
6 Marina's already suggested that we need to get  
7 the list of the top 20 conditions for children  
8 to factor in this. We could probably figure  
9 out what they are, but the question is, is it  
10 by volume or by cost. You'll tell me and  
11 we'll figure that one out.

12           We've got inpatient measures  
13 certainly and we have -- and then the question  
14 around safety measures. So, there are many  
15 ways of describing outcome measures and again,  
16 this is where we need your help what's the  
17 best way to do it so that we can describe to  
18 a large audience, you know, where we are and  
19 where we want to go.

20           So among the prevention measures  
21 you can see them. Charlie takes ownership for  
22 the Body Mass Index measure originally. But

1 you can see they're kind of across the board,  
2 a little smattering, you know, a couple for  
3 adolescents, a couple for newborns and a  
4 little of this and that. I mean they're not  
5 very cohesive so we need to think around how  
6 do we make this approach cohesive.

7 I mentioned that the patient  
8 experience with care, we do have several  
9 versions that are appropriate for kids. So  
10 these are endorsed measures so these are nice,  
11 we do have this area covered. But if there  
12 are other good measures out there that we need  
13 to deal with, we certainly don't want to  
14 overlook them.

15 The next one is our perinatal  
16 measures. Lee and I both worked on this  
17 project and several of the measures are  
18 appropriate measures of the newborn neonatal  
19 period. But again, this is a hospitalized  
20 focused effort, so it does have those  
21 limitations.

22 The next one, where are we on

1 outpatient measures. You can see we've got  
2 some for asthma, one for diabetes, a handful  
3 for ADHD, you know, otherwise again, mish-  
4 mash, not something that really describes  
5 health care for kids. And these are primarily  
6 process measures.

7           So, and then of course we talked  
8 about the inpatient measures. Okay. So again  
9 it's a bit disjointed, it came to us -- it's  
10 the result of years of various activities and  
11 here we are.

12           So we need to deal with the group  
13 of measures for kids in a systematic way, if  
14 you will. So NQF has several avenues to try  
15 and make our portfolio more appropriate for  
16 children.

17           One avenue is retooling measures  
18 appropriate for children, you know, some of  
19 those measures I mentioned that there's no  
20 reason they're -- they have an age cutoff at  
21 age 18 or something, you know, get some -- get  
22 those reconsidered and expand the age ranges

1 to whatever is appropriate.

2 Outcome measures for children,  
3 that's why you're here, okay. So among all of  
4 NQFs activities around child health, this is  
5 an important part of it. More outcome  
6 measures for kids and again, at the same time  
7 of any of our other efforts, measures  
8 applicable to the NPP national priorities and  
9 goals that are appropriate to children.

10 So we have all of these  
11 overlapping dovetailing events, but this group  
12 is in a position to help us identify existing  
13 measures or identify the measures that need to  
14 be developed that really can bring all of --  
15 a lot of these together and fill some very  
16 important gaps in the portfolio for  
17 measurement for children. So, next.

18 So as I mentioned, these are our  
19 project goals. We are going to be calling for  
20 measures to be submitted to this project for  
21 you to evaluate and consider and potentially  
22 recommend for endorsement.

1                   In January, one of the things  
2 we're going to specifically ask you to help us  
3 with and I'm going to lay it out there now so  
4 you can think on it, is where do we target  
5 that call for measures to be sure the people  
6 who need to hear it, do hear it.

7                   We have our usual avenues, you  
8 know, we send it to all of our members and we  
9 post it on our website and all this other good  
10 stuff, but we know that there are likely to be  
11 folks out there who many not get the message  
12 that way and you all potentially have contacts  
13 you know, that's the world you live in.

14                   Help us be sure that the message  
15 and the word gets out so that the measures  
16 that exist and are out there get submitted to  
17 the project. If we don't have them to work  
18 with, we're not going to be very happy with  
19 the end result.

20                   So that's sort of assignment  
21 number one and we'll, you know, think on it.  
22 We will actually formally be asking you to



1 send us or give us or offer up those  
2 suggestions a little bit later.

3           The other -- so once we have  
4 those, it would be nice if we had a group of  
5 measures, I don't know, are there six of them  
6 out there, are there 60 of them out there? I  
7 don't know, perhaps you have a better idea and  
8 you can tell us measures that we haven't seen  
9 already or that are not already on the list  
10 that may be available out there.

11           So we don't even know how big of  
12 an effort, how much work this is going to take  
13 actually. So, to the degree that you can help  
14 us, those will be useful. Kathy did you want  
15 to say something?

16           DR. JENKINS: I just wanted to  
17 offer that we do a regular surveillance of the  
18 landscape we call it the state of the universe  
19 of pediatric measurement in children that we  
20 have somebody updating.

21           And I would be more than happy to  
22 share like the latest and greatest version

1    which is as best as they could glean and it  
2    does incorporate the component of could be  
3    adapted for pediatric measures as long as  
4    everyone understands that we do have a  
5    hospital based focus and don't yell at us if  
6    your favorite isn't there.

7                   DR. WINKLER:  We are certainly  
8    eager to see any of the resources you all  
9    might be using in your lives to help pull this  
10   together.  That's why we use you to really  
11   help understand to get out into that world  
12   that you all work in so that we can be sure  
13   that we're as comprehensive as we can be.

14                   So I mentioned we'll do that call  
15   for measures so then your role will be to  
16   actually evaluate those measures.  NQF has  
17   standard measure evaluation criteria and we're  
18   going to go through those in some detail so  
19   that you understand them and have the  
20   opportunity to ask questions about them and  
21   about that evaluation process.

22                   But then as I keep mentioning and

1 I want to emphasize, as an equally important  
2 part of this project in terms of the goals, is  
3 creating this organizational structure, the  
4 framework if you will, to help us understand  
5 where the gaps are, identify them such that we  
6 can say we need measures, we need measures of  
7 functional status for kids with X, whatever,  
8 I mean you tell me.

9           But how do we figure out where  
10 those gaps are, how do we describe it, how do  
11 we explain this to folks to get the message  
12 out there that makes it very straight forward  
13 what we're looking for and that it's not  
14 ambiguous and it's not so generic that, you  
15 know, we don't get what we want in the near  
16 term, because that will be very important.  
17 Next one.

18           The keystone of what NQF does is  
19 developing consensus. And endorsement of  
20 measures is through our formal consensus  
21 development process and I just want to go over  
22 that briefly because you are overseeing that

1 process, so I'd like you to be familiar about  
2 what it is.

3           It is a formal process, the  
4 consensus that we built pays attention to our  
5 overall strategy for measuring and reporting  
6 within NQF, multi-stakeholder membership,  
7 you've heard that around the table, that's  
8 deliberate, intentional and a necessary part  
9 of the work that NQF does.

10           We want -- we include both  
11 private and public sector to the group  
12 possible, we want to look at the entire  
13 continuum of care. Okay, so particularly even  
14 though we're narrowed -- narrow ourself to  
15 outcomes, it's outcomes from any aspect of  
16 care.

17           So some of our projects are  
18 focused in on hospitals or they've been on  
19 outpatient. This isn't so much studying  
20 specific as it is the outcome measures rather  
21 than all measures of the type. So there are  
22 many ways we've organized some of our

1 projects.

2           Let me just give you this overview  
3 of the consensus development process. It is  
4 a step wise process, it is our responsibility  
5 to shepherd it through the process and meet  
6 all of the requirements. This process is --  
7 results in the measures being endorsed to be  
8 known as voluntary consensus standards.

9           This process actually comports to  
10 federal law, the 1996 National Technology and  
11 Transfer Advancement Act, 1996 as well as OMB  
12 Circular 119 which defines voluntary consensus  
13 standards.

14           And what that does is it obligates  
15 the federal government to use the measures  
16 when they're using measures if we have them  
17 available rather than doing their own thing.

18           And for the most part, over the  
19 last 10 years we have enjoyed a very good  
20 relationship with our friends in the federal  
21 government. They are actually funding this  
22 project and the work we're doing and so much

1 of the work we've done over the last few  
2 years.

3           And they have, to a large degree,  
4 held to that and they do use measures endorsed  
5 by NQF for all the variety of projects,  
6 particularly at CMS. And so the process is,  
7 you know, linear over time.

8           The steering committees role, and  
9 we'll go over some of the more details, but  
10 you oversee it. You help us make sure that we  
11 reach both the project goals as well as follow  
12 the consensus development process.

13           So we constitute the steering  
14 committee as a multi-stakeholder group. You  
15 are the decision making body, you do represent  
16 -- you're the proxy for the NQF membership.  
17 Remember the 400 members? Well we can't put  
18 them all in a room and have them talk, so we  
19 brought you as representatives as a proxy for  
20 them.

21           But we do want the perspectives  
22 from all the various stakeholders that's a

1 critical aspect of the work that NQF does.

2 So essentially what we'll be doing  
3 is reviewing the measures that get submitted  
4 to the project according to standard criteria.

5 You will then be making  
6 recommendations, which measures should go  
7 forward for endorsement as well as  
8 recommendations on things like which measures  
9 need to be developed, the framework that we're  
10 going to establish to say this is how we want  
11 to look in child outcome measures and, you  
12 know, we've got these, but we need these.

13 All of those will be  
14 recommendations from this group back to the  
15 NQF membership and sort of the world at large,  
16 and those are the draft recommendations. We  
17 package it up into sort of a standard format  
18 report and then it goes out for public  
19 comment, a 30-day NQF member and public  
20 comment.

21 We have developed a mechanism  
22 where those comments are submitted

1 electronically and then they get folded into  
2 an Excel spreadsheet. We will come back to  
3 you, how do we respond to these comments, look  
4 at the comments. Sometimes they just  
5 reiterate things we've already talked about,  
6 that's very common.

7           But sometimes you will have three,  
8 four, five, six organizations sort of with a  
9 theme that disagreed with something you did or  
10 think you didn't go far enough or whatever.

11           So, you want to potentially  
12 reevaluate some of your recommendations in  
13 light of those comments. And we do take the  
14 comments very seriously so we'll be coming  
15 back to you, we'll have a conference call,  
16 we'll pull out the things that we think you  
17 really need to pay attention to or you can  
18 pull out things you think that need to be, you  
19 know, redone.

20           And so the comment period is  
21 really important one because it's a dialog.  
22 You're creating a set of recommendations that



1 at the end of the day is a product of NQF.

2 You're acting as the representatives of the  
3 much larger group, so you get their input.

4           Once we have reconciled the  
5 comment period, the review and comment period,  
6 we then create a final report, and this is now  
7 the draft consensus standards that goes out to  
8 the NQF membership for voting, all right, they  
9 all get to vote, one of the benefits of  
10 membership is voting.

11           And the results of the voting and  
12 any comments that are submitted are taken to  
13 the consensus standards approval committee,  
14 which is a subcommittee of the board.

15           The board actually grants  
16 endorsements so they have designated a  
17 subcommittee to do the focused work around the  
18 measure endorsement process. So they look at  
19 the work that was done, be sure that we follow  
20 the consensus process, really look at the  
21 comments, really look at the general  
22 information that's come.

1           Each project has its own  
2 character, it has its own set of issues around  
3 it so they try and be sure that the process  
4 and the end product is really optimal to NQF.

5           And they make the recommendations  
6 to the board and the board ratifies them for  
7 the final endorsement as voluntary consensus  
8 standards. Then, there's a 30-day appeals  
9 period after that.

10           So all of those steps are  
11 important and they are rigorous and they are  
12 not flexible to allow us to maintain the  
13 integrity of the process. But as I said,  
14 you're an integral part of it, we will be  
15 keeping you, you know, the biggest amount of  
16 work for you guys is up front when we do the  
17 draft evaluations and the draft  
18 recommendations. What do you want to tell  
19 people we should do?

20           That will be the most -- that will  
21 probably be the most intense work, but you  
22 will certainly be involved in the review of

1 the comments that are submitted and then we  
2 will keep you up to date on what's happening  
3 as we go through the rest of it.

4 Let's see, when are we due for  
5 lunch? Okay, thirty minutes until lunch, can  
6 you hang in there. Are they ready at all  
7 earlier? Okay. All right. So are there any  
8 questions in terms of that? I'm going to go  
9 into some of the details, but I wanted to hit  
10 the high points so that you know what you got  
11 yourself in for. What did you volunteer for  
12 really.

13 DR. RAO: Reva, how do people find  
14 out about the public comment period and how is  
15 that --

16 DR. WINKLER: Again, it's another  
17 one of those we have the dissemination  
18 avenues, it's posted on our website, we do  
19 send it, information out to all of our  
20 members. Helen are there any other avenues  
21 we're using for announcing public comment?

22 DR. BURSTIN: There's also a

1 weekly blast that goes out to the public, very  
2 wide distribution, it's also on our website.  
3 And, you know, at least the last project Reva  
4 led on clinically measures we got 800  
5 comments. So that part of that process is --

6 DR. WINKLER: Yes, from about 100  
7 different --

8 DR. BURSTIN: -- very robust.  
9 Yes.

10 DR. WINKLER: Yes, it can be. It  
11 isn't always, but it can be.

12 MS. PARTRIDGE: I would also add  
13 that the various the eight councils to some  
14 degree take some responsibility for reaching  
15 out to people that they think might be  
16 interested.

17 When we did the perinatal  
18 measures, for example, the National  
19 Partnership who collaborated with Childbirth  
20 Connection, which is -- their director Maureen  
21 Corry was change order-chair of that project  
22 and using our combined e-mails and websites

1 and so on, we tried to reach lots of people we  
2 thought wouldn't necessarily know about  
3 through the traditional route.

4 And I'm afraid as a result, we're  
5 creating a lot more work for NQF. I think  
6 you're going to get a whole bunch of care  
7 coordination, Reva.

8 DR. WINKLER: Public comment is  
9 public comment. But again, this would be  
10 another role for you all because we will let  
11 you know it's now posted for public comment,  
12 go here. You can take that e-mail and send it  
13 to anybody you want to that you think would be  
14 interested.

15 So you guys are tied into the real  
16 child health community and can be a real asset  
17 in further dissemination so that we are  
18 hearing from the folks out there in terms of  
19 how it's playing in Peoria, if you will. So  
20 again, these are the kind of roles for you to  
21 play as we go through this process. Any other  
22 questions?

1 DR. MCINERNEY: Do, for instance,  
2 are part of the public the state Medicaid  
3 directors and medical directors of major  
4 payers, insurers that are particularly  
5 interested in child health? Yes?

6 DR. WINKLER: I guess I'm not sure  
7 exactly what your question, when -- you're  
8 asking are they involved? Yes, they certainly  
9 would be.

10 For instance, the Association of  
11 State Medicaid Directors is one of our  
12 members, you know, to the degree that they  
13 then distribute it to all 50 or however many  
14 state Medicaid directors, Lee can probably  
15 speak to it. That was one of the things she,  
16 you know, established before she went to the  
17 National Partnership I would guess.

18 MS. PARTRIDGE: Yes, actually the  
19 Secretary of Health and Human -- I forget what  
20 the departments are called in Michigan, but  
21 she's on the NQF board, there's traditionally  
22 been a seat for Medicaid on that board. And

1 there are a variety of ways that internally  
2 that the directors communicate with each  
3 other.

4 I think the new group that is  
5 really probably increasingly going to be very  
6 involved in this is this national, informal  
7 National Association of State Medicaid Medical  
8 Directors, which is sort of led by Jeff Schiff  
9 in Minnesota.

10 He co-chaired that committee we  
11 were talking about, the AHRQ committee and  
12 they -- when I was Medicaid director, we  
13 tended to have part time medical directors,  
14 many of them people who had given up  
15 practicing and wanted to kind of keep their  
16 hand in, but they really -- most of what they  
17 did for me was work on approval of transplants  
18 and special procedures and so on.

19 There's a new breed out there  
20 right now increasingly young doctors who make  
21 this a career and are career members of their  
22 state health departments or state Medicaid

1 program agencies. And they're very, very  
2 active and interesting.

3 DR. MCINERNEY: To sort of follow  
4 up, for the major national insurers, I'm not  
5 sure how we can ensure we've gotten the  
6 attention of the medical directors in those  
7 organizations that would have overview of the  
8 children's health part of their programs.

9 Because frankly, my experience is  
10 that it's difficult to get their attention,  
11 medical directors insurers attention about  
12 children's health. They seem to be want to  
13 concentrate on adult health, that's who's  
14 measures for lots of reasons.

15 So I just want to try and ensure  
16 that somehow we get their attention and then  
17 they pay attention and follow through. I  
18 don't know Charlie, maybe you can --

19 CO-CHAIR HOMER: No, I think it's  
20 a great point. It's certainly an issue we've  
21 wrestled with for a long time. I think to the  
22 extent that the national insurers have a



1 significant Medicaid business, I mean the call  
2 I was on earlier was a call with the Medicaid  
3 MCO sort of group.

4           So I think to the extent that  
5 Wellpoint, et cetera has a significant book of  
6 business in Medicaid, they will be interested  
7 in commenting on this, if nothing else for the  
8 quote, "burden" end quote, that this will  
9 place on their plans.

10           In fact, the core, certainly  
11 looking at the other committees I'm on, the  
12 core responders to this do tend to be the  
13 large plans or the largest. We tend to get,  
14 at least the committees I've been on, that's  
15 where you tend to get the most response, or at  
16 least a very significant response. So we'll  
17 try to get their attention.

18           CO-CHAIR WEISS: And I think it's  
19 also worth pointing out that since it's  
20 inception, NQF has made it a point of  
21 including the payers both private and public  
22 at the table and at all levels of activity

1 within the organization.

2           So, the actual ultimate debate and  
3 approval process will include input from  
4 people who represent at very high levels, the  
5 provider, community, the research community,  
6 the consumer community, but also the payer  
7 community. So there will be efforts made to  
8 reach out to them.

9           DR. WINKLER: One of our eight  
10 membership councils is on health plans and it  
11 has, I don't even know the number, but it's at  
12 least a dozen of the large, and certainly the  
13 large ones.

14           And the reason I know that is I'm  
15 just winding up our project on clinically  
16 enriched administrative data that is very much  
17 something we were focused in on and heard from  
18 the regularly.

19           So, they certainly know about NQF  
20 and to the degree we can, you know, put this  
21 one in front of them we'll do that.

22           DR. BURSTIN: Just one other

1 thought, a lot of the private plans really are  
2 very responsive to the large purchasers of  
3 health care who are very integrally related to  
4 NQF. There's a large coalition between the  
5 consumers and the purchaser groups, the  
6 consumer purchaser disclosure project who  
7 routinely come together to look at these  
8 issues.

9 DR. ZIMA: I had a question.

10 How's the collaboration with NIH going? I  
11 think just to follow up with Dr. Lieberthal's  
12 question earlier about the validity of the  
13 outcomes measures. Is there much discussion  
14 there with NIH as far as putting this on the  
15 agenda for more federal research money?

16 CO-CHAIR HOMER: I can answer that  
17 in part. I mean I think there are a couple of  
18 things. I mean obviously most of this work,  
19 as you know, most of the work that NQF kinds  
20 of measures we're looking at not only have to  
21 be conceptually correct and not only have to  
22 be reliable and valid, but then actually have

1 to be applied in the field.

2           So that tends to be some distance  
3 between NIH and I mean usually running through  
4 AHRQ and/or private foundations. So my sense  
5 is there's not a direct linear relationship,  
6 there may be special areas like the National  
7 Children's Study.

8           And again there was a lot of work  
9 to try to convince the National Children's  
10 Study to include some child health -- some  
11 health services measures in there work and I'm  
12 not actually sure where that came up, came  
13 out.

14           So, I mean the other thing that I  
15 think is included to some extent in some of  
16 our reports, it's when there are gaps, we like  
17 to feed that up often to AHRQ which then in  
18 theory will feed that up to NIH about gaps in  
19 availability of data, knowledge, measures.

20           So I think it's more a multi-step  
21 connection to NIH than a direct broad channel.

22           DR. WINKLER: But NIH is a member

1 of NQF and do they still have a seat on the  
2 board? Yes, that's what I thought. Just  
3 wanted to be sure I wasn't out of date.

4 So, NIH is definitely a member and  
5 active, you know, leader, partner, member  
6 within the organization so it's not -- there  
7 is a connection for sure.

8 But I would agree with Charlie for  
9 the most part, we tend to be a post-research  
10 effort and so a lot of their work may feed  
11 into things that ultimately we do, but usually  
12 they're a little bit prior to the work that we  
13 get into.

14 CO-CHAIR HOMER: I mean just  
15 building on this a little bit, Marina touched  
16 on this briefly, one of the things that  
17 happened as a result of the advocacy that  
18 Marina led in the -- for the CHIPRA  
19 legislation was the creation of a new program  
20 to develop pediatric measures, broadly.

21 And that measurement program is  
22 about to be launched, actually, we just

1 yesterday got an announcement from AHRQ, that,  
2 you know, watch this space come December  
3 they're going to be issuing an RFP for people  
4 who are interested.

5           So again, that's where I see the  
6 outcome of this group to the extent that we  
7 identified gaps in measures that will require  
8 development, which I'm sure we will.

9           We want to feed into that process  
10 so that it's either specified in the next  
11 round of our AHRQs language of RFP saying  
12 these areas were specifically identified. So  
13 I think those are the likely receptor sites  
14 for this kind of work.

15           CO-CHAIR WEISS: Charlie's very  
16 kind in saying I led it, I didn't, it was a  
17 collaborative effort, but I was certainly  
18 deeply engaged and happy to be so. I just  
19 really think it's worth paying attention to  
20 the fact that a whole purpose of NQF from its  
21 very inception has been to drive towards  
22 consensus around measures that are in fact

1 ready for prime time.

2           And what's really nice about this  
3 project and the reason I'm excited about being  
4 associated with it is because in being  
5 connected to NQF, we have the capacity not  
6 only to work our way toward the HHS, AHRQ, and  
7 CMS related body of activity, but also to use  
8 the consensus process through NQF to come to  
9 closure with the provider community, with the  
10 research community, with the consumer  
11 community and of course with the payers around  
12 a set of robust measures.

13           So the probability that we would  
14 be able to launch something here that really  
15 is working in the field is actually being used  
16 is greater than in any project I've been  
17 involved with before. So I'm pretty jazzed  
18 about this.

19           DR. WINKLER: Well I have a few  
20 more kind of just points in terms of the roles  
21 of the steering committee just that I went  
22 over briefly just to be sure I didn't forget

1 any. So like I say, find out exactly what you  
2 volunteered for.

3 I think for the most part this one  
4 I've gone over them and we don't want to  
5 minimize any one of these steps, but  
6 evaluating the measures will be a relatively  
7 intense exercise or activity depending on the  
8 number of measures we have and making those  
9 recommendations.

10 We will have an in person meeting  
11 of this group again in April and at that  
12 meeting is when we will be doing the  
13 evaluations and making those recommendation.

14 Now depending on how many measures  
15 we get, like I say if we get six, 60, we may  
16 need to have a few preliminary conference  
17 calls to kind of get ourselves organized  
18 around it. So we're leaving that open-ended  
19 until we understand exactly what the amount of  
20 work it is we have to organize for.

21 So be patient with us we'll let  
22 you know, that's still a little unclear but I



1 would anticipate that unless we -- if we've  
2 got more than just a handful of measures to  
3 deal with, we'll probably need to do some  
4 preliminary conference calls to start talking  
5 about some of the issues to make you familiar  
6 with doing that evaluation process.

7 CO-CHAIR HOMER: Reva, this will  
8 probably come up in the afternoon  
9 conversation, but maybe to wet our appetite  
10 for it, I mean if you look at the previous  
11 work, either the other 12 outcome committees  
12 you have other than this one, and all the  
13 previous work of NQF, you could slice every  
14 single one of them and say for infectious  
15 disease.

16 For example, children get  
17 infectious diseases and there are certainly  
18 outcome measures that people use in the field  
19 of pediatric infectious diseases, pulmonary  
20 disease, you know, cystic fibrosis, asthma.

21 I mean you name it, every -- so  
22 depending on how narrowly sliced or what the

1 criteria are, I mean we could have, you know,  
2 a wonderfully rich set of measures which would  
3 be great.

4                   But I mean have we thought, I mean  
5 because really, this is one of the issues that  
6 those of us in child health get sometimes  
7 frustrated about where with the adult side you  
8 have something on each specific condition and  
9 organ and in pediatrics there's one when in  
10 fact children have all the same number of  
11 organs that adults do and then they also  
12 develop.

13                   DR. WINKLER: You know to the  
14 degree you can help us figure out how to  
15 tackle that, feel free. Again, Charlie's had  
16 the experience of being on committees with us  
17 where, you know, child health has always been  
18 sort of the also on the margin if you will.

19                   How do we bring that in? And  
20 we're definitely open to hearing your best  
21 ideas of how we can do that. You know, to the  
22 degree that the important conditions exist

1 both in kids as well as with in adults,  
2 aligning it because nothing happens big that  
3 I know of on their 18th birthday that changes  
4 their physiology.

5           So, you know, I think you bring up  
6 a real good point and I think it has a lot to  
7 do with measure development out there focus.  
8 There's just a lot more focus developing being  
9 done by organizations that don't feel they  
10 have competency in pediatric issues is the way  
11 I've heard it placed.

12           We don't have pediatricians, so we  
13 don't know how to do that. So I think there  
14 are some of the limitations we have  
15 experienced, so if you want to help try and  
16 bring those in, bridge that, help us figure  
17 out how to get rid of the dark lines between  
18 kids and everyone else and, you know, where  
19 should it blend.

20           That's why -- I think this is a  
21 challenging way to think about it and how best  
22 is one of the reasons you're here.

1 CO-CHAIR HOMER: Kathy?

2 DR. JENKINS: And Charlie just to  
3 make the point because I think there's a rich  
4 opportunity there, it might be equally  
5 important to say which ones are not relevant  
6 in kids and make that an explicit line as  
7 well.

8 Because again in my recipient role  
9 a lot of the measures, as people have looked  
10 for endorsed measures, have simply been  
11 applied in kids and especially when you get  
12 into the high stakes measurement often there's  
13 issues of risk adjustment, small sample sizes,  
14 things that are left out of the definition  
15 that are being imposed.

16 So, vetting all of that would be  
17 potentially extraordinarily important in both  
18 directions.

19 MS. PARTRIDGE: Kathy mentioned  
20 sample size and that might be a way we might  
21 find ourselves sorting these down the road.  
22 Certain conditions are not going to occur very

1 often and depending on what you're measuring  
2 whether you're looking at a health plan or  
3 clinic or a particular practice, it would make  
4 no -- they would never implement it because  
5 they wouldn't have -- they wouldn't be likely  
6 to have the case.

7           So that doesn't mean we shouldn't  
8 endorse it, it just means that you might find  
9 that the adoption rate would be pretty  
10 limited.

11           CO-CHAIR HOMER: Good. Yes,  
12 Helen.

13           DR. BURSTIN: Yes, just one more  
14 thought. I mean again, a process going  
15 forward, we would also be very happy to bring  
16 to this committee everything that's going  
17 through the other two committees and ask you  
18 to look at it through the lens of which of  
19 these are actually applicable to kids.

20           I mean one of things we've  
21 discovered at times is we look at a measure  
22 and we go, okay, medication reconciliation.

1 Kids get admitted to hospitals, kids take  
2 drugs, but why does that measure start at age  
3 65.

4                   So those are the kind of things, I  
5 think, if we bring it to you and we'll try to  
6 organize that process if you could give us  
7 feedback on which of those would be  
8 applicable, that would be really useful. It's  
9 as much as we can harmonize it so that it's  
10 one measure applicable to both, obviously that  
11 would be best of all.

12                   CO-CHAIR WEISS: And going back to  
13 a point that Reva mentioned earlier.  
14 Apparently when the Department of Health and  
15 Human Services asked that this project be  
16 initiated, the request was framed in the  
17 context of the 20 top conditions for Medicare  
18 patients.

19                   And it just occurred to me that  
20 maybe we ought to ask for the same bit of  
21 information. And I would cut it at least two  
22 ways, one is cost and the other one, because

1 that will be very interesting to the payers of  
2 course, and then the other one, of course is  
3 frequency.

4 MS. PARTRIDGE: Yes, I can tell  
5 you probably otitis media, respiratory, I mean  
6 for common, yes, you'll see -- and of course  
7 all the well child. For cost, it's your  
8 premises and a few the CPs, spinal bifida, but  
9 --

10 CO-CHAIR WEISS: I don't know that  
11 this would be ultimately the way we would go,  
12 but I'm sure it would be interesting to know.

13 MS. PARTRIDGE: No, but I think we  
14 -- and it will vary tremendously by state as  
15 well, I suspect. There will be some very  
16 common and then you'll see there may be for  
17 others, there may be certain -- more frequent  
18 then you would expect.

19 I mean I don't, for example, I  
20 don't imagine a lot of sickle cell shows up in  
21 Idaho.

22 DR. SCHWALENSTOCKER: Just I

1 wonder if you could say just a little bit more  
2 about the HHS or CMS that overall charge for  
3 this program, is that for measures that will  
4 be used for say the hospital RK2PU Program  
5 \*\*\*12:19:38, I love that acronym or PQRI, is  
6 there more information you have about the  
7 intended use of the measures or kind of the  
8 origin of the project?

9 DR. WINKLER: Helen probably  
10 better than that. I mean, I'm not aware of  
11 anything that specific just to be used in  
12 their programs. And so you can kind of  
13 extrapolate, but Helen may have additional  
14 information.

15 DR. BURSTIN: I mean there's  
16 clearly been an interest in trying to expand  
17 their base of outcomes based measures not  
18 surprisingly moving away from some of the more  
19 process measures to more outcomes. There's  
20 not, as I know any, immediate plans to say,  
21 okay, we have these measures let's put them  
22 into a program.



1                   But as you know, the measures we  
2 put forward can be used in that manner, so  
3 nothing clear there other than the fact that  
4 there's a strong interest in getting these  
5 measures out there in a way that aren't  
6 potential for future use.

7                   But again, their initial interest  
8 was okay, here's the top 20 Medicare  
9 conditions and we said, okay that's a little  
10 limiting, could we add children and could we  
11 at least add mental health as a starting  
12 point.

13                   DR. MCINERNY: I don't know  
14 whether people have thought about going back  
15 and looking at what the measures that Rita  
16 Mangione-Smith developed with Beth McGlynn or  
17 the report that she showed that less than half  
18 the kids received appropriate care. I'll  
19 present -- I do have a little bias there, I  
20 actually was involved in the development of  
21 those to some extent. I was one of a panel  
22 that went to Brand and worked on that awhile,

1 quite awhile ago.

2 I think they were, by today's  
3 standards, they're probably pretty crude and -  
4 -

5 CO-CHAIR HOMER: And I think  
6 they're mainly processed aren't they, of  
7 whether things were done in offices, that  
8 shouldn't have been done.

9 DR. MCINERNEY: Yes, I think you're  
10 right, and I don't know how many of them were  
11 outcomes, but I just wondered because there  
12 may be a few that we could look at and see if  
13 make sense and then probably would need to be  
14 developed better than they were back then.

15 CO-CHAIR HOMER: And again one of  
16 -- that kind of thing, one of those that  
17 informs our thinking about this, but again  
18 it's up to the steward or the owner of the  
19 measure will then have to decide whether  
20 they're willing to submit it and tell us  
21 basically all -- they do have to tell us all  
22 the specifications as well, which some may not

1 want to do.

2           And then they also have to commit  
3 to sort of maintaining it at least for a  
4 period of time. So there are -- there may be  
5 measures -- we may discover that there will be  
6 measures out there that people aren't willing  
7 to submit.

8           There may also be measures that  
9 look good and have been used, for example, in  
10 a research study and are well validated, but  
11 have never been applied in sort of a clinical  
12 either accountability or improvement process.  
13 So that's going to be some of the filtering  
14 that will happen once we start going through  
15 the process.

16           MS. PERKINS: This is Jane. In  
17 terms of the top 20 conditions that children  
18 experience, if there could, I don't know  
19 whether this exists, but if there could also  
20 be that top 20 list for children who are --  
21 who typically I guess suffer from health  
22 disparities, does that kind of thing exist?

1 I know that for African American  
2 populations often things like that do, but --

3 CO-CHAIR HOMER: I mean we could  
4 certainly look at things like MEPS data,  
5 National Survey of Child Health Data,  
6 certainly those are available to be stratified  
7 by race and by in some cases insurance for  
8 MEPS so we'd be able to get that kind of data.

9 DR. SCHWALENSTOCKER: I want to  
10 say that every year in ambulatory pediatrics  
11 isn't there a report on the top conditions in  
12 outpatient and inpatient settings? I can't  
13 remember who the authors generally are.

14 CO-CHAIR HOMER: Yes. That's  
15 usually Lisa and Denise Daugherty are usually  
16 the authors of that and I mentioned it to  
17 Helen.

18 DR. SCHWALENSTOCKER: Right. But  
19 with that, my recollection is that those top  
20 conditions vary quite a bit depending on the  
21 age subgroup. So in adolescents you're going  
22 to see very different top conditions than in

1 very young children.

2 CO-CHAIR HOMER: Sure. I mean  
3 adolescent the most common reason and the most  
4 common costs for adolescents is childbirth, so  
5 absolutely clear and second is psychiatric  
6 disease and third is trauma.

7 So I mean it is -- or I might have  
8 the trauma and psychiatric disease switched,  
9 but I know that childbirth is leading. So,  
10 clearly and clearly different at the younger  
11 age where, you know, again, childbirth for the  
12 baby and then the cost of neonatal care and  
13 variety of congenital conditions. So, yes  
14 that's a great point.

15 DR. LIEBERTHAL: For acute  
16 conditions, those reports on the top 20  
17 include things like acute otitis media, lower  
18 respiratory tract infection and having been  
19 involved with the developing guidelines in  
20 those areas in looking at those guidelines for  
21 potential writing of measures, it's  
22 extraordinarily difficult to write process

1 measures let alone outcome measures.

2 DR. WINKLER: Anything else  
3 because I'm at a logical stopping place and  
4 we're lunch.

5 CO-CHAIR WEISS: Have people take  
6 a break and pick up their food and do we want  
7 to continue working during lunch or shall we  
8 take a little break?

9 CO-CHAIR HOMER: No, let's say --

10 CO-CHAIR WEISS: All right, let's  
11 take a break then.

12 MS. PERKINS: Should I call back  
13 into this same number then at a set time?

14 CO-CHAIR HOMER: Yes.

15 DR. WINKLER: Actually just stay  
16 on is preferable.

17 CO-CHAIR WEISS: Or just stay on.

18 MS. PERKINS: Okay. I can just  
19 stay on.

20 CO-CHAIR WEISS: Put it on mute  
21 and all that.

22 MS. PERKINS: Yes, okay.

1 CO-CHAIR HOMER: Very good.  
2 (Whereupon, the foregoing matter  
3 went off the record at 12:25 p.m.  
4 and went back on the record at  
5 1:17 p.m.)

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1 -- they would all have to be evaluated against  
2 these criteria. So it's important to have a  
3 sense of what they are.

4           And just historically, NQF has  
5 always had criteria, they've always had been  
6 four major criteria which we'll talk about.

7           But through the years as things  
8 have evolved, I think it was about a year ago,  
9 August of 2008 it was a sense that a lot of  
10 measures that perhaps weren't as robust as we  
11 might like where being endorsed and there was  
12 a need to try and raise the bar a little bit.

13           And so, the criteria was reviewed  
14 by the CSAC and revised a bit. And so we're  
15 talking about the revisions. And so -- and  
16 the whole point of that revision effort was to  
17 clarify, strengthen and recommend changes in  
18 order to do a couple of things.

19           We do want to link them to the  
20 national priorities. So to the degree that  
21 they do have that linkage to the NPP  
22 priorities and goals we want to highlight

1 those and also to higher level performance  
2 measures. We really want to raise the bar.

3           So realize that if you worked with  
4 us in the past, in the distant past we are  
5 trying to do more. So that perhaps measures  
6 that we may have endorsed five years ago would  
7 not meet the criteria today.

8           So greater measure harmonization.  
9 We've actually gotten to the point that if the  
10 measures aren't harmonized, we won't push them  
11 forward for endorsement. It tends to be a  
12 great incentive to get the harmonization done  
13 with folks. And we've had to be fairly  
14 pointed in the need to get harmonization done.

15           So it isn't, you know, I think  
16 there's a lot more work that can be done in  
17 that area and it's always a fine line because  
18 we are dealing with someone else's  
19 intellectual property. But by the same token,  
20 the benefits of harmonization are just so  
21 obvious that it is a significant priority for  
22 us.

1                   Greater emphasis on outcome  
2 measures. That's why you're here. And for  
3 process measures a tighter outcomes process  
4 link, which was real important. You know,  
5 what is the evidence that they're -- that this  
6 process measure is linked to an important  
7 patient outcome.

8                   That will be less of an issue for  
9 us because we do have outcome measures, but  
10 nonetheless, be aware that those are the  
11 questions that stakeholders are asking, you  
12 know, why is this important, it's because.  
13 Okay, next.

14                   So in terms of the changes, the  
15 emphasis, we've always had four criteria of  
16 important scientific acceptability,  
17 feasibility and usability, but a couple things  
18 have changed.

19                   Importance has morphed into  
20 important to measure and report. And this is  
21 something that people often get very confused  
22 in their mind because there are a lot of

1 really important things out there, but not  
2 everything is important to measure and expend  
3 energy and resources to measure report and do  
4 something with.

5           So something that may be important  
6 doesn't necessarily benefit from an important  
7 measure. So -- and this becomes a must pass  
8 criteria. And you'll see there are several  
9 subcriteria that help define what we mean by  
10 important to measure and report.

11           But it definitely has to do with  
12 the balance between the information generated  
13 versus the burden it is to collect and crunch  
14 the data.

15           Scientific acceptability, and this  
16 is of the measure properties, it isn't so much  
17 the evidence that's actually an importance,  
18 but it's like that measure, are the  
19 specifications precise, do you have adequate  
20 definitions, what's the reliability, what's  
21 the validity, what's the appropriate risk  
22 adjustment, you know, the measure itself, is

1 it a good, scientifically grounded.

2 Feasibility, again how easy will  
3 this be to implement. What are the issues in  
4 implementing, particularly as it comes to data  
5 source. And one of the criterias on it if  
6 you're not using electronic sources, what's  
7 your near term path for, you know, specifying  
8 this measure for improved feasibility using  
9 health IT.

10 And then usability, greater  
11 emphasis on harmonization, usability is you  
12 generate information when you do a measure  
13 it's the so what factor.

14 Who out there is going to be able  
15 to use that information to do something with  
16 it, make choices, effect change, understand  
17 better, whatever, but is it usable in that  
18 fashion. So this is how they have morphed  
19 over time. Next one.

20 We also have -- yes.

21 CO-CHAIR HOMER: May I ask you a  
22 question?

1 DR. WINKLER: Sure Charlie.

2 CO-CHAIR HOMER: So on some of the  
3 other committees I've been on they have a  
4 technical panel that answers that number two  
5 question of the scientific validity. Do we  
6 have that luxury in this?

7 DR. WINKLER: No, actually given  
8 the narrow topic area of child health we will,  
9 you know, topic but broad, broad by narrow, we  
10 actually don't have any technical advisory  
11 panels immediately constituted if there --  
12 depending on the measures we get, and that's  
13 why it's a little bit uncertain going forward.

14 If there were a need to identify  
15 some technical advisors that you feel would be  
16 necessary to help you, we can do that. But it  
17 just, in the work plan in anticipation we  
18 don't have that set up. The main steering  
19 committee it's looking all the other  
20 conditions actually do have several TAPs  
21 helping them out.

22 DR. RAO: Just a question. Do we

1 have anyone from CMS, for example, that can  
2 just tell us well you can't measure that, they  
3 don't record that or if they could give us  
4 quick advice.

5 DR. WINKLER: We can always ask  
6 that question but realize that CMS is not our  
7 only --

8 DR. RAO: Yes, I know.

9 DR. WINKLER: Yes.

10 DR. RAO: It's a possibility.

11 CO-CHAIR HOMER: So what you're  
12 saying is it's not in the plan now, but if we  
13 were to get five measures, I mean we happen to  
14 have great strength in cardiology here, but  
15 for example there is, and you've already had  
16 something on that, but for example were we to  
17 get 10 measures that were looking at something  
18 like that and they all use different severity  
19 of illness categories, we might be able to  
20 pull in, if we didn't happen to have on this  
21 committee --

22 DR. WINKLER: Right.

1 CO-CHAIR HOMER: -- the technical  
2 expertise that we needed?

3 DR. WINKLER: Yes. I think that's  
4 one of the problems in project planning is  
5 really without knowing what measures we have.  
6 So I think we have to have -- leave it a  
7 little bit open ended to see what we're  
8 actually going to be looking at before we  
9 know.

10 But we certainly can bring that  
11 additional expertise in if it's your  
12 directions. Couple of things just so that you  
13 know about the conditions for a measure to be  
14 evaluated by NQF and the measure is either in  
15 the public domain or we have an intellectual  
16 property agreement signed by the measure  
17 steward.

18 The measures have -- are not --  
19 can't be black box measures. We can't hide  
20 significant aspects of the measures, they have  
21 to be open source, they have to be made  
22 available.



1           You have to be able to see all of  
2 the elements, all of the details, you know,  
3 all the codes, all the exclusions, all the  
4 equations, whatever it is, you need to see it  
5 all. And so that's important.

6           Each measure, there might be a lot  
7 of public domain measures out there, but if  
8 they don't have an owner that takes  
9 responsibility for them that will act as a  
10 steward going forward, then we're not able to  
11 deal with it because we need a relationship  
12 with the measure steward going forward.

13           Because measures need to  
14 periodically be updated, revised, we have  
15 questions, someone has to take that  
16 responsibility. As we've talked about  
17 earlier, the intended use must include both  
18 the public reporting, it's the accountability  
19 part that is NQFs focus as well as quality  
20 improvement.

21           So the basic, you know, lower  
22 level internal QI kind of measures are really

1 not what NQF is looking for we're looking for  
2 the more significant measures.

3           And then we do ask one of the  
4 criteria that we have is that the information  
5 be complete. We now use an electronic  
6 submission process that helps us manage just  
7 a large amount of data and it helps us create  
8 the output for you to look at on your  
9 evaluation form.

10           But if half of it's left blank,  
11 there's very little for you to work with or  
12 any of us to work with. And we're really  
13 trying to minimize extraneous attachments and  
14 extra documents that we have to, you know, go  
15 through.

16           So to give you a standardized  
17 format so you always know where the  
18 information about validity and reliability is  
19 in your standard evaluation form that we'll  
20 give you, we do require that.

21           So these are just the kind of  
22 conditions we put up front on the measure

1 developer when they're submitting measures to  
2 us. So we just wanted you to be aware of it.  
3 You know, 10 years ago, you know, a brief  
4 description of a measure sent by an e-mail was  
5 good enough.

6           We can't deal with that anymore,  
7 things have got to be a lot more detailed and  
8 organized and complete in terms of  
9 information. So, just the last thing in terms  
10 of timeline, where we're going for this whole  
11 group.

12           You're here at the first meeting,  
13 we're going to be doing the call for measures  
14 right after the first of the year, it's a 30  
15 day call for measures. We want -- we'll need  
16 your help to try and be sure we get the word  
17 out so that we can keep to that timeline  
18 because we actually need all the measures in  
19 our hands, you know, just as soon as that  
20 closes in 30 days.

21           Because, like I say, if there are  
22 six, you know, we can relax a little bit, if

1 there are 60, we're going to have some  
2 interesting issues with volume.

3 Our second meeting is -- will be  
4 in April, which indeed is the meeting we will  
5 ask you to be doing the evaluation and  
6 recommendation of those measures. And Melissa  
7 will organize asking you all when, you know,  
8 what the best date, two days for a meeting in  
9 April will be.

10 And as I said, if indeed we get 60  
11 measures and we have to break them down and do  
12 something and do a couple lead in conference  
13 calls we'll do that.

14 We will let you know as soon as we  
15 know how many measures there actually will be,  
16 but it will be at the end of the 30 day period  
17 once the submission closes, we'll check the  
18 spreadsheet and count them up and see how many  
19 we've got and see how they spread in terms of  
20 topic areas and if there's some natural  
21 divisions and breakouts.

22 And then, then we'll take a look

1 to see if there's additional expertise or  
2 whatever that we may need. So we will  
3 certainly be back with you once that closes to  
4 let you know the work that we have ahead. So  
5 is there any questions, kind on -- these are  
6 just some real basic how NQF operates issues  
7 so that you at least have a general  
8 introduction. Kathy?

9 DR. JENKINS: I just -- what  
10 happens next then? Because I have a feeling  
11 that a lot of these measures, you know, we're  
12 going to have to use what's available now and  
13 some of them may be those time limited  
14 endorsements and then like how does this go  
15 forward and stay together with the national  
16 process and AHRQ and others.

17 DR. WINKLER: The HHS contract  
18 that we're working under actually is a four  
19 year, potentially four years of work, and  
20 we're already working on next year's work plan  
21 and the following years work plan and since  
22 outcomes is really such a high priority, the

1 idea that there will be some follow up work  
2 depending on what we do, it will lead to the  
3 next phase of work that we can anticipate  
4 going forward.

5           So we're likely to have, you know,  
6 avenues to if we recommend these measures need  
7 to be developed, people get busy and develop  
8 them, then, you know, in a year or two we are  
9 likely to have another avenue of looking for  
10 outcome measures to fill those gaps.

11           That really is one of the goals  
12 from the Agency in terms of doing this work  
13 and outcomes is just a huge priority. So this  
14 is just sort of a first effort and then the  
15 second wave will be another chance to make it  
16 better, if you will.

17           Any other questions? Jane did you  
18 have a question or anything, out there in the  
19 sky?

20           MS. PERKINS: No. I'm just sort  
21 of, you said 60 so many times I'm starting to  
22 freak out every time I hear you say something.

1 DR. WINKLER: Yes. I don't mean  
2 to do that to scare you, I just am trying to  
3 be extreme.

4 DR. CLARKE: I have kind of a  
5 comment.

6 CO-CHAIR HOMER: David had a  
7 question, go ahead.

8 DR. CLARKE: I have kin of a  
9 comment and a question. It seems to me that  
10 moving forward the framework that we need to  
11 end up with has got to be some kind of a  
12 hierarchical relationship because other than  
13 that, it's going to be very difficult to  
14 integrate it into the various databases and so  
15 forth so that it can be used easily.

16 And I don't know that it really  
17 matters whether we, you know, start with the  
18 hierarchical groups and then, you know, sort  
19 of use that framework to recruit measurements  
20 or whether we just collect all the  
21 measurements and then form the groups later or  
22 maybe some combination of both. Can you

1 comment on that?

2 DR. WINKLER: What we're going to  
3 do this afternoon is we have a couple of  
4 things to just put on the table for your  
5 consideration and then I'd like you all to  
6 discuss it.

7 And from the things you've already  
8 mentioned and the things that you're going to  
9 talk about, we're going to actually go out and  
10 get some of these things, you want a top 20  
11 list, well we'll go see if we can find them  
12 tonight and we'll bring them back to you  
13 tomorrow.

14 And we'll try and do a bit of an  
15 organization of your discussion and have a  
16 revisit of it tomorrow morning so we can kind  
17 of see what did you get, how might we put it  
18 together, do a little bit of thinking on the  
19 part of the staff tonight, to help see if we  
20 can get the beginnings of that organizational  
21 structure.

22 Quite possibly it will be a first



1 pass and there will be discussion tomorrow  
2 morning which then we can give you the second  
3 draft by e-mail and we can do one of those  
4 sorts of things, so over the next couple of  
5 weeks we can kind of build this.

6           But this is the beginning while  
7 we're getting to know each other and we're  
8 here, we can have an opportunity to do this  
9 kind of collective thinking and see if we can  
10 figure out what this picture should look like.

11           And so however you think it may  
12 work best for you, you know, we'll try and do  
13 whatever we can to support it, okay?

14           Okay. I've just got a couple of  
15 things, as I mentioned we wanted to offer just  
16 a couple of thoughts on outcomes to help you  
17 set the scope, and that's essentially what  
18 we're doing.

19           With any project, we have to know  
20 what the boundaries, you know, what's in,  
21 what's out because otherwise if the entire  
22 universe is in, it will drive you crazy. So

1 we have to know exactly what box are we going  
2 to try and live in.

3           And it's not necessarily a slam  
4 dunk decision, so we do want to give you the  
5 chance to consider some ways of looking at  
6 this.

7           Just, we are dealing with  
8 outcomes, so keep that in mind. And going  
9 back to the granddaddy of them all, you know,  
10 the definition of an outcome measure and  
11 Donabedian's classic construct is referring to  
12 changes both desirable and undesirable in  
13 individuals and populations that are  
14 attributed to health care.

15           Okay? So that's where we're at.  
16 That's kind of what we're talking about. Does  
17 anybody have any questions or comments on that  
18 as a definition? Ellen?

19           DR. SCHWALENSTOCKER: So being  
20 sort of a Donabedian devotee, I've had this  
21 sort of nagging concern today about, and I'm  
22 respectful of focusing on outcomes and

1 recognizing that that's part of our scope, but  
2 it seems to me -- or that is our scope, it  
3 seems to me that process outcomes link is  
4 going to be very important for us.

5 I think Reva, you mentioned  
6 earlier that process outcome link is  
7 considered important when considering process  
8 measures, but it seems to me we've got to  
9 think that way in terms of outcomes measures  
10 or how are we going to link them to improving  
11 -- link them to specific interventions, if you  
12 will, to improve care?

13 DR. JENKINS: Ellen, do you mean  
14 they need to be actionable or you need to know  
15 what the actions are that influence the  
16 outcomes that can be improved upon is that  
17 what you mean or?

18 DR. SCHWALENSTOCKER: Yes. That's  
19 what I mean. Thanks.

20 DR. WINKLER: I'm sure that will  
21 become a discussion point when you look at  
22 each of the various measures. But to the

1 degree that evidence-base -- there is an  
2 evidence-base that can answer that question,  
3 it is one of the questions in the measure  
4 submission.

5           So that information is there.

6 It's a little bit more tenuous on an outcome  
7 measure than it is on a process linking it to  
8 an outcome. So we'll have to evaluate each  
9 one on its own merits.

10           DR. MCINERNY: To me the classic  
11 example is immunization rates. I mean, that's  
12 really a process measure, but you can't wait  
13 to see that if you gave a kid a hepatitis B  
14 vaccine at birth that they didn't 40 years  
15 later get hepatitis B. Most of us won't be  
16 around that long.

17           But, so, you know, can you use the  
18 process measure as a proxy because we know  
19 that immunizations do greatly reduce disease.  
20 So that outcome is -- there is a pretty strong  
21 link between that process and the long term  
22 outcome. That's always to me a question.

1 CO-CHAIR HOMER: It always comes  
2 up for immunization. I think hospitalization  
3 as a quote, "outcome measure" is another one  
4 that's, you know, on the fence I would say.  
5 And we're just going to have to discuss that.

6 DR. RAO: Just a comment, in terms  
7 of immunizations for example, isn't a process  
8 outcome just being offered immunization or  
9 offering immunization for the parent rather  
10 than actually receiving it just because if  
11 they refuse then you still followed the  
12 process per se.

13 DR. WINKLER: I think that there's  
14 interest actually in knowing all of those  
15 different elements of it, but actually the  
16 intervention that is related to outcomes is  
17 actually receiving the immunization.

18 So that is actually the effector,  
19 the action item though I think there's a lot  
20 of discussion around, you know, patient  
21 refusal and that and capturing that data may  
22 be of use. But the one that's actually going

1 to be related outcomes for protecting them  
2 against disease is going to be receiving the  
3 immunization.

4 We actually had a specific project  
5 focused on harmonization around immunization  
6 measures and the immunization guru is very,  
7 very strongly felt, you know, it's getting the  
8 immunization that's the thing that counts.

9 DR. LIEBERTHAL: When we talk  
10 about process measures and outcome measures we  
11 also have to look at who are we measuring.  
12 When you're talking about a health care  
13 organization, the measuring the outcomes for  
14 their population is relatively easy to do and  
15 meaningful.

16 The problem you have when you're  
17 evaluating providers is that they do not  
18 directly control the outcomes when you're  
19 talking about chronic disease. For example,  
20 in asthma a patient may see multiple providers  
21 plus socioeconomic adherence many, many other  
22 things contribute to the outcomes that are

1 unrelated to what the provider did.

2           And it becomes a real difficult  
3 problem when you try to attribute outcomes to  
4 individual providers.

5           DR. WINKLER: In this particular  
6 case we are not designating the level of  
7 analysis for outcome measures per se and many  
8 of these measures, for a lot of technical  
9 reasons, but for a lot of philosophical  
10 reasons may only be applicable at larger  
11 levels of analysis such as at a hospital  
12 level, at a plan level, at a large group  
13 level.

14           One is just sheer numbers, but I  
15 think each measure would have to be evaluated  
16 on a -- as an individual at one, the measure  
17 developer is going to designate what levels of  
18 analysis they believe it's suitable for and  
19 then that will be part of your evaluation as  
20 to what levels of analysis you believe that to  
21 be that they presented the case for or not.

22           So it's conceivable that among the

1 list of outcome measures that you recommend,  
2 some will be at certain levels and some -- and  
3 none of them may be at individual provider  
4 levels, but may be at larger levels of  
5 aggregation and analysis, and that's perfectly  
6 fine.

7 CO-CHAIR HOMER: The only  
8 restriction that we're proposing here is the  
9 one Donabedian talks about, that is that we  
10 can reasonably attribute these to health care.

11 DR. WINKLER: Yes.

12 MS. PERKINS: I actually -- I have  
13 a question about that.

14 CO-CHAIR HOMER: Yes, it's a good  
15 -- go ahead.

16 MS. PERKINS: Yes, what does it  
17 mean? Does it include education, does it  
18 include things like personal care services  
19 that children with chronic needs really do use  
20 and need?

21 CO-CHAIR HOMER: Well for example,  
22 so I think on the table for discussion, so



1 maybe by the end of the day we'll have an  
2 answer to it, when we were just talking about  
3 this as Chairs across my e-mail list was a  
4 report from some California foundation talking  
5 about the, you know, impact on academic  
6 achievement of child health.

7           So in that context it's probably  
8 fair for us to at least at a first pass say to  
9 put on the table whether we want an index of  
10 academic achievement as a potential outcome  
11 measure.

12           I'm not saying on or not, but I  
13 mean I think that's a potential outcome  
14 measure that we should at least think about is  
15 that in or out of scope and then I think we as  
16 a group probably would want to wrestle with,  
17 well what proportion of variance, for example,  
18 in a population outcome measures could be  
19 achieving at the health care and would we be  
20 willing to hold any health care organization  
21 accountable for that outcome.

22           And if we would say yes, then, you

1 know, we probably should at least be within  
2 our scope. So that would be my guess. But as  
3 opposed to, well again we're not really  
4 looking at processes.

5 I mean if we -- I don't think we  
6 should be looking at processes within schools  
7 or, you know, whether there's a school lunch  
8 program or not even though that may have a  
9 health outcome that we care about, you know,  
10 we're looking at outcomes.

11 But I think to me the critical  
12 question is can the outcome or are we or would  
13 somebody be willing to hold a health care  
14 delivery organization at some level between  
15 provider and Kaiser, you know, probably at  
16 that range accountable for an outcome.

17 DR. PERSAUD: Well I think what  
18 that raises is really that one outcome isn't  
19 depending on just one thing, it's a matter of  
20 attributable cost.

21 CO-CHAIR HOMER: Right.

22 DR. PERSAUD: And so the reason

1 that immunizations are almost a proxy for  
2 lower infection rates is because they are such  
3 a large proportion regression contributor to  
4 the outcome.

5           For me in prevention medicine, I  
6 think we should start to entertain those  
7 discussions about academic achievement because  
8 I think there is a theoretical relationship  
9 between the health care provider than academic  
10 achievement.

11           It's just that the contribution is  
12 varied and maybe even variable across systems  
13 and maybe those are the kinds of things that  
14 we should start to address.

15           CO-CHAIR HOMER: And again, as the  
16 materials, we said when we start looking at  
17 outcome measures there's an assumption that we  
18 will need to include, risk adjustment for  
19 different categories of risk and/or  
20 stratification which is the approach that NQF  
21 uses for dealing with socioeconomic and racial  
22 disparities rather than risk adjustment.

1           So that's -- that, for example,  
2 race or a class is a stronger determinant of  
3 outcome or a major determinant of some of  
4 these broad outcomes is kind of accepted and  
5 is a given and not a reason that we shouldn't  
6 include an outcome that has those as major  
7 determinants.

8           We would just need to see when we  
9 see a measure come in, the measure proposer  
10 would have to tell us how the measure either  
11 adjusts for that or proposes to collect data  
12 and stratify that depending on what the risk  
13 characteristic is.

14           I'm sorry, there are a couple --  
15 the ones that were in order, I know Ellen has  
16 had her hand up for awhile. Who else has --  
17 I prefer to keep a queue here. So it was  
18 Ellen, Kathy, Lee. Okay, great.

19           DR. SCHWALENSTOCKER: So just a  
20 scope question, again, sometimes we call  
21 things like experience with care intermediate  
22 outcomes, are we considering them or is that

1 an open question, should we consider them in  
2 the scope of outcomes measures?

3 DR. WINKLER: It's more your  
4 second question, should we.

5 CO-CHAIR HOMER: Okay. Kathy?

6 DR. JENKINS: Charlie when you  
7 just said that there had to be attributions to  
8 a health care organization or entity I guess  
9 I got a little confused because I thought that  
10 there could be both public health perspective,  
11 population based health outcomes that for  
12 example the state of Massachusetts could fill  
13 ownership of or an accountable role to play  
14 that could potentially be something within the  
15 boundaries of your question before about  
16 attribution that we could consider. Is that  
17 not correct?

18 CO-CHAIR HOMER: So as that  
19 evolved, I've been on different committees and  
20 the sense in the past I've been on was if it  
21 was that the health care system, health care  
22 delivery system had to have a potential impact

1 on that.

2 DR. JENKINS: Well in some ways  
3 you could say that a state is a provider of  
4 health care in a variety of ways, certainly as  
5 a payer, as an insurer through their Medicare  
6 programs.

7 So, you know, I don't think it's  
8 too big of a stretch and in fact one of the  
9 things Bonnie is going to propose is how do  
10 we, you know, look at these two together from  
11 the more traditional way that NQF has always  
12 looked at, you know, specific levels of  
13 analysis versus, you know, we do care about  
14 the population and the contributions to the  
15 larger -- how do we make that jump?

16 Where are they connected? What  
17 are those connections? And this, particularly  
18 around children seems to be a good project to  
19 explore some of that to figure out how we  
20 might begin to think that through. And so  
21 that's why Bonnie's going to talk a little bit  
22 about some of these things together.

1           I think a lot of these are a  
2 little bit open and you're input is helping us  
3 try and figure out maybe the best way to go  
4 forward. So it's not as if there's some  
5 absolutes here, but I think Charlie's right.

6           I don't think we want to range so  
7 far out there that we're worrying about what's  
8 going on in the schools too much, you know,  
9 and hold the school accountable as opposed to  
10 need to be something that's a little more  
11 health care oriented to keep it at least  
12 within a reasonable kind of purview for us to  
13 deal with.

14           CO-CHAIR HOMER: Lee?

15           MS. PARTRIDGE: Charlie you're  
16 raising the schools of course is a very  
17 significant departure from what we normally do  
18 around an NQF steering committee table. And  
19 I was thinking, we do talk about missed school  
20 days, which is often tied, particularly to  
21 control of certain chronic conditions.

22           And that tie could be quite tight

1 I think. If we end up going in that  
2 direction, I think then the call for measures,  
3 Reva, really has to say to people this is not  
4 a traditional call for measures.

5 DR. WINKLER: Let me do something,  
6 go ahead two slides. This is a list of the  
7 types of outcome measures that actually we've  
8 used in the HHS proposal, but I also put to  
9 the main steering committee who are doing, you  
10 know, all the 20 conditions things and asked  
11 them.

12 You know, because I've heard  
13 people say oh that's not really an outcome  
14 measure, maybe it is maybe it's not. So the  
15 question I would pose to you is, do you think  
16 these are -- should be included within your  
17 scope of what are outcome measures.

18 And you'll see, whoever asked the  
19 question about patient experience with care,  
20 it's up there. But let's just take them one  
21 by one and be sure that you would include  
22 these, because this actually is setting the



1 framework for what the main steering committee  
2 is going to use.

3           They actually want to see these  
4 type of measures against their 20 conditions,  
5 that's their framework, okay. And it may not  
6 be what you want to use, but it's certainly  
7 one way to go.

8           One is patient function or  
9 symptoms or sort of the health related quality  
10 of life. When you talk about function, to me  
11 a measure of function might be missed days of  
12 work, missed days of school, able to do your  
13 usual activities, whatever.

14           So measures of function is it an  
15 outcome measure or not?

16           CO-CHAIR HOMER: Sure.

17           DR. WINKLER: Yes. Okay. Nobody  
18 disagreed. Then we have intermediate clinical  
19 outcomes and we've got several measures like  
20 this, you know, blood pressure control of, you  
21 know, less than 130 over 80 kind of thing.  
22 Good intermediate outcome.

1           The third one is patient  
2   experience with care or some assessment of  
3   patient knowledge of understanding of their  
4   health condition, health risk status,  
5   motivation, kind of those patient thinking  
6   kinds of things. Outcome measures?

7           CO-CHAIR HOMER: I would have a  
8   split vote on that to tell you the truth.

9           DR. WINKLER: You'd have split  
10   vote?

11          CO-CHAIR HOMER: Yes, I think you  
12   could --

13          DR. WINKLER: What do you want to  
14   split?

15          CO-CHAIR HOMER: I would say  
16   experience of care is an outcome measure, it's  
17   one of the core dimensions of quality and  
18   knowledge per se, is not in my view an outcome  
19   because knowledge is not really -- knowledge  
20   is a beautiful thing, but it doesn't relate to  
21   either health related behaviors or health  
22   outcomes. So I personally would exclude

1 knowledge.

2           But that's -- so that's why I said  
3 I might be a splitter on that and not  
4 consider them all part of the same.

5           DR. LIEBERTHAL: Patient, I don't  
6 know, knowledge and understanding and their  
7 adherence is a function of a system that  
8 provides the education in a way that the  
9 patient can absorb it and understand it, which  
10 is not our normal way of interacting with  
11 patients.

12           And I think that this is a key  
13 outcome when looking at overall health because  
14 if the patient, if we have not conveyed the  
15 knowledge at the level that the patient can  
16 understand it and effect their behavior and  
17 I'm not quite sure the best way to do that,  
18 the outcomes may be disconnected from the  
19 health care provided.

20           DR. CLARKE: Well, it seems to me  
21 that the outcome, I agree patient experience  
22 with care which is patient satisfaction is an

1 outcome. But the outcome is the behavior and  
2 the adherence to care and the acceptance of  
3 the prescribed care and the actual follow  
4 through, that's the outcome.

5 I don't think you can measure  
6 accurate the knowledge, understanding,  
7 motivation and all that stuff.

8 DR. MCINERNEY: Well I think now  
9 that we have motivational intervention  
10 available, we probably could significantly  
11 improve outcomes for things like smoking  
12 cessation and prevention or treatment of  
13 obesity; however, I don't know if that link  
14 has been thoroughly studied.

15 But it seems to me that the good  
16 old loose weight because I told you to or stop  
17 smoking because I told you to clearly doesn't  
18 work. And on the other hand if one uses  
19 motivational intervention that -- I've seen  
20 some indication that that probably is far more  
21 likely to improve outcomes in the long run.  
22 But that's going to be asking a lot of the

1 system.

2 DR. PERSAUD: I think that bullet  
3 three is probably a continuum of processes  
4 that lead up to an outcome and we've got too  
5 many things probably lumped together.

6 I would throw in that probably the  
7 big buzz word in all motivation now is  
8 readiness for change in case you want to add  
9 anything in there that's going to give you an  
10 idea of where the person is moving between  
11 understanding to doing something, I think  
12 readiness for change is in there.

13 So I would propose that maybe  
14 three just be separated out or we need to just  
15 understand. I think three is a continuum that  
16 some of those are process, some of those are  
17 intermediate and some are outcome.

18 DR. RAO: Yes, I think one of the  
19 concerns that I think Charlie raised as well  
20 as I think you can have absolutely no  
21 knowledge of something and can still follow  
22 the behavior and have a positive outcome. And

1 of course you can be very knowledgeable and do  
2 absolutely nothing.

3 The other problem is measuring  
4 those knowledge outcomes would be extremely  
5 difficult I think from a systems standpoint  
6 too.

7 DR. ZIMA: I do agree we have to  
8 unbundle this. And one resource is Barbara  
9 Rimer I-M-E-R, she has a textbook on health  
10 behavior and health provider education. And  
11 what she taught me through that book, and it's  
12 in the fourth edition now, is that there's  
13 three decades of work on social sciences.

14 And to me things like knowledge,  
15 attitudes, norms, it's already been elegantly  
16 written. And what IOM is really encouraging  
17 us to do is to integrate these behavioral  
18 theories in our interventions. So I think it  
19 maybe needs its own box as far as potential  
20 mediators of quality.

21 CO-CHAIR HOMER: So what I heard  
22 in that discussion was I think general

1 recognition that experience is an outcome and  
2 some sense that the rest of them are on a  
3 continuum towards leading to outcomes and  
4 which of those we actually include.

5           A, we need a better categorization  
6 of them and this is a little less  
7 sophisticated than it should be. And I think  
8 once we have that, I think we would need to  
9 revisit further whether we consider -- the  
10 sense I had was most people think these are  
11 important steps on the way to behavior change.

12           Whether they should be measured,  
13 all measured and considered as quote,  
14 "outcomes" I think we have not yet come to  
15 consensus on. That's what I -- did I capture  
16 that?

17           DR. WINKLER: Okay. We can try  
18 and redraft it based on your input. Because  
19 I think some -- because I'm thinking of this  
20 as being sort of the backbone of this call for  
21 measures, you know, we are looking for  
22 measures of these types and describe them.

1           So the degree we can make them as  
2 clear and understandable to a broad audience  
3 is important. So we'll kind of redraft them  
4 and get them back to you for further thinking.

5           The next one is service  
6 utilization as a proxy for outcome and under  
7 this comes readmissions --

8           CO-CHAIR HOMER: Or admissions- --

9           DR. WINKLER: -- or admissions for  
10 things that perhaps didn't need to happen or  
11 ER visits or, you know, those sorts of things.  
12 That's what's meant there. Any question about  
13 those being outcomes?

14          DR. LIEBERTHAL: Yes, when you use  
15 the term service utilization and then relate  
16 that to an example is readmissions, I'm not  
17 quite sure I understand the wording or how  
18 service utilization --

19          CO-CHAIR HOMER: for example it  
20 would be --

21          DR. LIEBERTHAL: Yes, I'm not --  
22 the terminology doesn't --



1 DR. WINKLER: Work for you?

2 DR. LIEBERTHAL: -- work for me.

3 I wouldn't have come to readmissions after  
4 reading that statement.

5 DR. WINKLER: Okay.

6 CO-CHAIR HOMER: So it's not  
7 question --

8 DR. LIEBERTHAL: It's not clear.

9 CO-CHAIR HOMER: -- with the  
10 content, it's more the words that are  
11 described --

12 DR. LIEBERTHAL: The clear, it  
13 isn't clear to somebody who hasn't seen it  
14 before.

15 CO-CHAIR HOMER: But the concept  
16 though, for example, the potentially  
17 preventable hospitalization for asthma of  
18 something like that would be a kosher -- you  
19 consider that an outcome measure?

20 DR. LIEBERTHAL: Yes.

21 CO-CHAIR HOMER: Okay. Bonnie.

22 DR. ZIMA: There seems to be a lot

1 of emphasis on avoiding of excessive services,  
2 but how about dropout? How are you handling  
3 that?

4 CO-CHAIR HOMER: So meaning either  
5 under use --

6 DR. ZIMA: Yes.

7 CO-CHAIR HOMER: -- people who are  
8 not receiving therapy that they should be  
9 receiving?

10 DR. ZIMA: Yes. It's certainly a  
11 big issue in mental health. I mean the  
12 average number of visits for a child in a  
13 community mental health center is one.

14 DR. WINKLER: These tend to be,  
15 you know, the more efficacy kind of measures  
16 in terms of in process it's how many of them  
17 are doing whatever needs to be done. The  
18 related outcome though would be what we'd be  
19 looking for.

20 So even if patients drop out,  
21 presumably their outcome will suffer as well.  
22 So that would be captured in the actual

1 outcome measure for this particular approach.

2 You know, that's the difference between

3 process and outcome measures I think.

4 CO-CHAIR HOMER: I think that's  
5 right. So I guess the question, if you had no  
6 other data but simply data that said 46  
7 percent of children didn't complete their  
8 course of children in one program compared to  
9 10 percent in some, you know, would that be  
10 sufficient information on outcome to allow you  
11 to make a decision that the outcomes are  
12 better in one or the other assuming the  
13 treatment is efficacious?

14 DR. ZIMA: It's interesting  
15 because there is a body of literature that  
16 shows that mental health care is ineffective  
17 in real world treatment settings.

18 CO-CHAIR HOMER: Ineffective?

19 DR. ZIMA: Ineffective using  
20 either weightless control or children who have  
21 dropped out of care.

22 CO-CHAIR HOMER: So that would say

1 that -- so that would answer your question  
2 which is that we couldn't use --

3 DR. ZIMA: I don't know.

4 CO-CHAIR HOMER: -- outcome --

5 DR. ZIMA: It's a murky issue, but  
6 I think dropout is a big problem with our  
7 child mental health.

8 CO-CHAIR HOMER: So again, one of  
9 my general principles on sort of quality  
10 measures, again, this is more my philosophy  
11 maybe not my Chair role, but maybe it is.

12 I mean, a quality measure  
13 particularly if we're either asking -- we're  
14 either holding somebody accountable, which  
15 means basically you'll get paid more or less  
16 or you'll get a contract or not less  
17 \*\*\*1:58:57 or you're going to do a quality  
18 improvement program which is we would like you  
19 to achieve a higher level of performance.

20 You have to have a fair degree of  
21 confidence that what you're articulating is  
22 quote, "The right thing to do," I mean the

1 right thing for the right patient at the right  
2 time.

3           So if it's a murky area, which  
4 will come up I think at our conversations  
5 repeatedly over the next several months,  
6 probably means not ready for prime time. I  
7 mean not ready for us to endorse as a measure  
8 that NQF is going to stand behind and say  
9 plans or practices or hospitals or providers  
10 can and should measure this element.

11           It's a very different framework  
12 from a research framework. Kathy?

13           DR. JENKINS: I had the same  
14 comment as Allan about the wording, but what  
15 I read into it was the question about whether  
16 costs of care could be considered an outcome  
17 measure and I guess my answer is yes  
18 particularly through the lense of efficiency.

19           And if that's not what was meant  
20 by the fourth bullet then I think it should be  
21 up there somewhere.

22           DR. WINKLER: Yes, cost of care is

1 an outcome measure. I can tell you that just  
2 in the weirdness and the way these projects  
3 are set up, they actually is the different  
4 projects looking at the cost of care elements  
5 of it.

6           So I think we'll put it there, but  
7 it won't be what we call for just because by  
8 contract it's out of scope not by  
9 conceptualization it's out. But I don't -- I  
10 think putting it there to include it so we  
11 know that we're not deliberately excluding it  
12 from our thinking is appropriate. So thank  
13 you Kathy.

14           Any other comments or questions,  
15 we move down the list. Okay. The next one is  
16 non-mortality morbidity related to disease  
17 control and treatment.

18           And sort of classic one is, you  
19 know, amputation as a result of poor diabetic  
20 control, you know, serious preventable  
21 morbidity or dialysis or something like that  
22 that on the long term. So I think there are

1 some other ones.

2 And then the next one is health  
3 care required adverse event or complication.  
4 These are the not so desirable outcomes and  
5 then of course mortality.

6 So the question I'll ask you with  
7 the wordsmithing and the caveats we've already  
8 talked about, this to me seems like it forms -  
9 - is going to form the basis for our call for  
10 measures that we're looking for measures of  
11 all of these types.

12 I think we'll need more, but is  
13 there any -- can you, off the top of your head  
14 at this point, think of anything else that's  
15 not there? And we're going to have further  
16 discussion, but --

17 CO-CHAIR HOMER: Development. So  
18 I mean to some extent you could put it under  
19 your patient function, symptoms, health  
20 related quality but again that's sort of --

21 DR. WINKLER: You're talking about  
22 physical development, right?

1 CO-CHAIR HOMER: I'm talking about  
2 physical, cognitive --

3 DR. WINKLER: Cognitive, the whole  
4 thing, right.

5 CO-CHAIR HOMER: -- emotional  
6 development. I'm talking about all the  
7 dimensions because that's, I mean that's the  
8 critical outcome for childhood that's not  
9 captured well.

10 DR. WINKLER: Does everybody agree  
11 that that's particularly especially for  
12 children?

13 DR. DOCHERTY: I saw that under  
14 that patient function, health related quality  
15 of life, physical, mental, social, I was  
16 looking for that and that's where --

17 DR. WINKLER: Okay.

18 CO-CHAIR HOMER: Yes, I think that  
19 is where it would --

20 DR. DOCHERTY: -- needs to be more  
21 specified.

22 CO-CHAIR HOMER: -- fit. I think



1 for us, I think we should specify that in  
2 order to get it.

3 DR. WINKLER: Okay. Works for me.

4 CO-CHAIR WEISS: I like it. If  
5 we're finished with that I want to go to that  
6 same bullet but with a slightly different  
7 item.

8 DR. MCINERNEY: Just a comment on  
9 what Charlie said, I think, you know, the idea  
10 of getting children into early intervention if  
11 we do a good screening job for developmental  
12 delays is at a -- being in early intervention,  
13 is that an outcome, no probably not.

14 But is it a good proxy for an  
15 outcome or do we have to follow them through  
16 their early intervention and see if somehow  
17 they were ready for kindergarten because of  
18 the early intervention because you identified  
19 as developmentally delayed too. I have a  
20 problem with knowing exactly how you -- where  
21 you go with that.

22 CO-CHAIR HOMER: Without answering

1 the question, I think what we'll have to  
2 wrestle with is the certainty of the link.

3 I mean really that's a process  
4 outcome connection that is being in an early  
5 intervention program, process that leads to an  
6 outcome and it depends on how confident we are  
7 that that process -- I mean if it was as clear  
8 as immunization linked to the other ones, then  
9 it would be fine.

10 If it weren't, then it's a process  
11 measure and maybe a very legitimate process  
12 measure that we would want -- that a committee  
13 that would be looking at, you know, child  
14 development process measures would look at.  
15 The only caveat I have is whether that counts  
16 as service utilization as a proxy for an  
17 outcome.

18 DR. ZIMA: It's an interesting  
19 point because I think that we know that  
20 detection doesn't necessarily improve access  
21 to care. So as we kind of go down this slow,  
22 I mean how much would a recommendation of

1 detection be linked then to recommendation  
2 related to service use than to outcome.

3 CO-CHAIR HOMER: I'd be absolutely  
4 confident in saying for example, doing a  
5 developmental screen is a process measure and  
6 not an outcome measure. And even filling out  
7 a referral form, the EPS, you know, early  
8 intervention program is a process measure and  
9 not an outcome measure.

10 Whether somebody's enrolled in an  
11 early intervention program versus whether they  
12 are ready for school at age five, which would  
13 be a better outcome measure I think is really  
14 for us to wrestle with.

15 DR. RAO: Just thinking about a  
16 possible, you know, outcome measure that might  
17 cross a lot of different boundaries and  
18 categories, what about physical fitness if  
19 somebody -- I would propose that as an  
20 outcome, where would that fit in? Is it a  
21 functional sort of thing, is it really related  
22 to health care or --

1 DR. DOCHERTY: That seems to me if  
2 we're going to add a bullet on growth and  
3 development it seems to fit under that.

4 DR. RAO: Yes, as a separate thing  
5 under growth and development.

6 DR. DOCHERTY: Yes. Well as part  
7 of the growth and development would be  
8 physical functioning, you know, appropriate  
9 levels physical functioning at the age. And  
10 I wasn't understanding were people questioning  
11 whether or not growth and development could be  
12 an outcome at all?

13 Because we certainly use that a  
14 lot with the chronically ill children. If  
15 they've been in the hospital we look at, you  
16 know, what kinds of growth and development  
17 outcomes are we seeing when they're -- so we  
18 use that a lot for the chronically ill.

19 DR. CLARKE: I had a comment about  
20 morbidity first and then about mortality.  
21 Actually bullets five and six I think are the  
22 same thing, they're both clinical morbidity.

1                   And what we found when we tried to  
2 objectively evaluate morbidity in the large  
3 group of cardiac surgery patients that we  
4 looked at was that for most adverse events  
5 that are temporary and reversible length of  
6 stay in the hospital serves as a fairly good  
7 surrogate for measuring that.

8                   However, the occasional durable  
9 adverse event like a neurological injury or  
10 heart block or, you know, a few other sort of  
11 like permanent dialysis those kinds of things,  
12 are very, very difficult to measure because  
13 you find that unless you weight them just  
14 incredibly heavy, they contribute nothing  
15 because they're so infrequent.

16                   And so just some words about  
17 measuring morbidity and how difficult it is  
18 and how we may, you know, I think it's  
19 important, but you may have to accept  
20 something that less than perfect in order to  
21 make it usable.

22                   And then as far as mortality and

1 also morbidity together, I think that in the  
2 pediatric arena, this is where some sort of  
3 risk or complexity adjustment is vital.

4 Because if we were going to make these public,  
5 it's key by the door \*\*\*2:07:45.

6 CO-CHAIR HOMER: Well agreed. And  
7 just on my comment earlier, just echoing the  
8 NQF standards, the NQF acknowledges that  
9 outcome measures need to be risk adjusted  
10 unless proven otherwise. So, Kathy?

11 DR. JENKINS: The other thing I  
12 don't see there is I see patient functioning,  
13 but I don't see patient and family functioning  
14 which in a pediatric context I think probably  
15 does deserve to be an outcome measure, whether  
16 it's parent satisfaction, family functioning,  
17 what -- across the board to kind of -- maybe  
18 that's about scope, but I think it needs to be  
19 there.

20 CO-CHAIR WEISS: Well we probably  
21 need to say that about a number of these  
22 items, especially for the smaller children.

1 We're really talking about parental  
2 satisfaction rather than talking about toddler  
3 satisfaction, for example.

4 I wanted to go to bullet number  
5 one under the patient function and just say  
6 from the perspective from those of us who are  
7 in the world of advocacy and trying to see to  
8 it that things are reimbursable and whatnot  
9 through various programs be they private or  
10 public, one of the things that we run into a  
11 lot is the issue of function.

12 And the standard that we run up  
13 against is that a function is not improving  
14 then it cannot be reimbursed. But for  
15 children especially it seems to be necessary  
16 to stipulate that maintenance of function is  
17 important. So I would like to see that there  
18 in some way.

19 MS. PERKINS: Also under Medicaid  
20 you don't have to be improving to be  
21 reimbursed for children.

22 DR. JENKINS: Jane, could you

1 speak up?

2 MS. PERKINS: I just said also  
3 under Medicaid you don't have to be improving  
4 to be -- for there to be a requirement to  
5 reimburse. The service just needs to be  
6 correcting or ameliorating the problem.

7 CO-CHAIR WEISS: That is  
8 absolutely correct and it was moving mountains  
9 to get to that place.

10 MS. PERKINS: Yes, no kidding.

11 DR. JENKINS: And along those same  
12 lines, and maybe this is already implicit in  
13 just naming the overall outcomes like growth  
14 and development like Charlie did, but I'm  
15 looking for something that I think is much of  
16 an issue in kids than in adults, which is  
17 attainment of optimal functioning as opposed  
18 to an adult's where there's loss of function,  
19 that inability to attain what one should have  
20 had available.

21 I don't know how exactly to put  
22 that in, it's there kind of tangentially now,



1 but for kids for the same reason you're  
2 looking for maintenance, I think we need to be  
3 explicit about that.

4 CO-CHAIR HOMER: And I think that  
5 ties into the IOM report that was e-mailed  
6 around last night that sort of defined child  
7 health in the context of obtaining optimal  
8 health and growth. Ellen, did you have a  
9 comment?

10 DR. SCHWALENSTOCKER: Yes. I'm  
11 thinking of the National Priorities  
12 Partnership priority on coordination of care.  
13 And I'm thinking of things about receiving  
14 appropriate follow up and whether that would  
15 be a process measure or whether it would be a  
16 flip side of service utilization, but I'm  
17 wondering if we need something like that in  
18 there.

19 CO-CHAIR WEISS: Well it certainly  
20 would apply in the case of inpatient based  
21 screening and identification of disorders or  
22 conditions or whatever on which follow up is

1 required on discharge.

2           So again, I agree with you, I'm  
3 not sure whether that's process or whether  
4 that where it really belongs is in the EHR it  
5 seems to me. But it would be nice to be able  
6 to get at that transition and coordination of  
7 care issue.

8           CO-CHAIR HOMER: I mean my gut is  
9 that that's a process and we need to think of  
10 what the outcome is that that would be likely  
11 to address and it may be very variable  
12 depending on what the condition is and it may  
13 be a satisfaction or experience of care or  
14 duplication efficiency measure outcome as for  
15 the --

16           CO-CHAIR WEISS: Well just taking  
17 as an example hearing screening in the  
18 hospital and the child is identified through  
19 the screen as having a deficiency, but that's  
20 going to be picked up in the outpatient  
21 setting.

22           It's process initially in the

1 intermediate phase, but then what has to  
2 happen and who is the provider held  
3 accountable?

4 CO-CHAIR HOMER: So seeing as we  
5 do a lot of work in that area, the next level  
6 of processes was -- I mean the recommendation  
7 of course is that they be screened in the  
8 newborn they have confirmation by one month  
9 and you have definitive -- I think one month  
10 and definitive diagnosis by six months. I'm  
11 sorry or definitive treatment actually started  
12 by six months. So --

13 CO-CHAIR WEISS: So do you wait  
14 for treatment then and --

15 CO-CHAIR HOMER: So the question  
16 is what the outcome -- what's the outcome is  
17 that it's done each of those three things as  
18 a proxy. We actually had this intense debate  
19 at the U.S. Preventive Service Taskforce and  
20 fortunately we got them to reverse their  
21 findings on that.

22 Well I'll tell you, I mean that

1 the U.S. Preventive -- so the U.S. Preventive  
2 Service Taskforce viewed as the relevant  
3 outcome was employability, school function.  
4 That was the outcome.

5           The debate was sort of the quality  
6 of the literature that linked early screening  
7 to those outcomes and what ultimately  
8 convinced them was I think enough studies  
9 feeling that the bias involved in those  
10 studies didn't -- wasn't sufficiently strong.

11           So that's what got it to be a  
12 recommendation over time, but it really was  
13 based on the long term outcomes.

14           We made the argument, and we in  
15 this group can make the argument that for  
16 example parental satisfaction, which clearly  
17 parents are much more comfortable knowing that  
18 their child has -- whether their child can  
19 hear or not, but we made that argument.

20           And I still think it's valid. We  
21 did not convince the taskforce, at least at  
22 the time I was on it, that that was a

1 sufficiently credible outcome on which to base  
2 the judgement.

3 DR. WINKLER: just a thought, if  
4 your initial process is screening, the outcome  
5 -- the intermediate outcome would be treatment  
6 because if you didn't, you know, and then the  
7 treatment is an intermediate step towards the  
8 more longer term outcomes that you were  
9 talking about.

10 So perhaps you could make the  
11 argument for --

12 CO-CHAIR HOMER: Treatment by six  
13 months for example which is what the --

14 DR. WINKLER: Whatever it is, yes.

15 DR. DOCHERTY: Or another way to  
16 look at it, if you know, depending on where  
17 the service is expected to be, so when  
18 something is, you know, well known, a process  
19 is well known to lead to an outcome like  
20 screening we now know and it's been supported  
21 in the literature for decades that if you  
22 screen you get these outcomes, then doesn't

1 that process then become an outcome in a  
2 particular service.

3           So, you know, in these -- where  
4 the screening is supposed to be done, then it  
5 becomes an outcome for them not a process  
6 because it's supposed to be done there. We  
7 know it leads to this.

8           CO-CHAIR HOMER: I think it still  
9 gets down to the strength -- it's a balance of  
10 I think the strength of the linkage and then  
11 probably the feasibility and the time delay of  
12 the -- that would be my guess.

13           So for example, I keep hearing it  
14 doesn't seem reasonable that you have to  
15 measure whether somebody can have a job and  
16 graduate from high school, which was what the  
17 studies -- that's what the taskforce was  
18 holding, that doesn't seem reasonable to me.

19           But whether having, for example, a  
20 newborn hearing screen done, which is clearly  
21 a process is in itself a sufficiently -- would  
22 meet your charge for -- well probably for an

1 outcome measure if you're confident that  
2 that's going to -- use your microphone, I'm  
3 sorry.

4 DR. DOCHERTY: I was just going to  
5 say I would argue that for certain services  
6 it's an outcome then because we know that it  
7 has to be done in order for -- the process  
8 then becomes an outcome over a period of time.

9 It's like thyroid screening now,  
10 you know, for infants, it's now an outcome.  
11 You don't have to wait for the disease -- to  
12 ensure that quality care is being given.

13 CO-CHAIR HOMER: It wouldn't fit  
14 on our list so for example thyroid screens,  
15 that's an even clearer one that wouldn't fit  
16 on our lists that we could either modify the  
17 list to include it.

18 DR. WINKLER: I think what you're  
19 getting at is something much like Tom was  
20 talking about was proxies for outcomes like  
21 immunization rates because, you know, not  
22 getting something is really the outcome, but

1 that becomes pretty hard to measure.

2           So actually the receipt of the  
3 immunization, which is the protective element  
4 may be the more feasible outcome or proxy for  
5 the outcomes that you can measure and the  
6 question is, are there others of that ilk  
7 which I think puts us in the gray zone in  
8 terms between process and outcome.

9           And we may not have any of these  
10 measures, you know, it will just depend as we  
11 try and characterize the call for measures  
12 what we're looking for. We do need to kind  
13 of, you know, figure out where the boundaries  
14 are and that's what this conversation is sort  
15 of all about.

16           Personally, again, maybe it will  
17 come back to this. I mean my preliminary  
18 recommendation is that we not include those  
19 processes at the start and put out the call  
20 for proposals and see if we get things back,  
21 and if we get zero then we go back and sort of  
22 say, how about processes that you have a lot



1 of confidence in and come back.

2 CO-CHAIR WEISS: I agree.

3 DR. WINKLER: This is looking to  
4 sort of form the basis of the call, but I  
5 think there's more to it than that and we do  
6 want to talk about some other elements of it.

7 A couple of things, if you go down  
8 to the next slide Melissa, this was something  
9 that was brought up by members of the main  
10 steering committee that I thought were very  
11 interesting for you to consider and that is,  
12 you know, the source of information about  
13 outcomes.

14 And they really kind of boiled  
15 down to three, the patient reported outcomes  
16 folks, the world they live in, use this  
17 construct. And one is information that you  
18 get from the patient or caregiver. You know,  
19 they're doing the observation. This is sort  
20 of your history if you're the clinician it's  
21 like, you know, what happened, did you get  
22 better, can you do something.

1                   CO-CHAIR HOMER: Or pain for  
2 example.

3                   DR. WINKLER: Or pain, did your  
4 pain go away or can you do, you know, can you  
5 resume doing whatever it was you couldn't do  
6 and that's the reason you came to see me.

7                   But the information comes from the  
8 patient. And then other information about  
9 outcomes could be clinician observation, an  
10 assessment, you know, decreased leg edema  
11 after instituting treatment, you know,  
12 diuretic therapy for your heart failure,  
13 whatever, any of those sorts of things.

14                   And then the other outcome is more  
15 -- other type of outcome information would be  
16 physiologic which is something you could  
17 measure that is measurable by anybody, blood  
18 pressure, the lab result, whatever.

19                   In fact, one of the interesting  
20 things that the IT folks are dealing with is  
21 where does data come from and it's conceivable  
22 that things like blood pressure measurement

1 don't come through a clinical per se, but come  
2 from the machine that someone took the  
3 measurement with.

4           So these are the more, you know,  
5 same thing with a lab result, so they're much  
6 more objective, physiologic kind of  
7 perimeters. And so the question would be is  
8 it desirable to have outcome measures that  
9 utilize all of those sources of information.

10           Because there are some people who  
11 feel like the patient reported outcome side of  
12 it, either too hard to do, too squishy, I  
13 don't know, something. But do you feel that  
14 all of those would be important to be sure we  
15 didn't, you know, deliberately exclude any of  
16 those as potential outcome information.

17           DR. RAO: Reva just a question, on  
18 patient reported outcome, does that include  
19 documentation by a clinician of improvement or  
20 is it directly collected from patients?

21           DR. WINKLER: I mean I think that  
22 would depend on how a measure could be

1 specified. I mean I could see it both ways.

2 I could see you documenting a  
3 series of standardized questions on like a  
4 patient with asthma, you know, have you missed  
5 school in the last three -- any days of  
6 school, have you done this, have you done --  
7 you have a standard set and that would be  
8 documented in your chart, in your EHR easily  
9 retrievable data elements.

10 But it also could be a survey. So  
11 I don't think we're being prescriptive about  
12 it, but I think there are potential options  
13 for getting this information.

14 MS. PARTRIDGE: Reva, would your  
15 physiological include things like hospital  
16 admissions? Is that --

17 DR. WINKLER: I would imagine it's  
18 pretty -- I mean it's pretty -- yes, it's a  
19 fact.

20 MS. PARTRIDGE: Yes.

21 DR. WINKLER: Nobody has to  
22 observe or interpret it just is. Yes, I would

1 guess so. The group that does this uses  
2 physiologic and I always call -- I kind of  
3 think of it as objective. I mean just very  
4 fact based. I mean there's no interpretation  
5 necessary, it just is.

6 DR. PERSAUD: I guess I'd be  
7 reluctant to exclude anything because I think  
8 the way you get the information might not be  
9 telling you whether something's necessarily an  
10 outcome. As Charles point out, patient  
11 satisfaction surveys, and in the STEEEF the  
12 patient-centered perimeters are going to be  
13 patient reported, there is mostly. So I'd be  
14 reluctant to exclude anything.

15 DR. ZIMA: Yes. I struggle a  
16 little bit with physiologic because we've  
17 already talked about service use. And we  
18 might want to go back again to Donabedian  
19 roots and what probably call that type of  
20 outcome and absolutist outcome and which is  
21 kind of like the no-brainers, the concrete  
22 ones.

1           So vital signs, lab results, we've  
2 had some discussion about service use and, you  
3 know, is that the place we also put treatment  
4 adherence. So for example, you know, plasma  
5 levels of a certain drug, right, or Medicaid  
6 claims data. Agency data is not one of the  
7 data sources up there, should they consider  
8 that?

9           DR. WINKLER: Yes. I think I  
10 probably shouldn't have used the word data  
11 source as, you know, data stream, if you will.  
12 The question who's creating the information  
13 not necessarily how it came to you.

14           MS. PERKINS: This is Jane  
15 Perkins, I'm going to have to get off and go  
16 to this other thing, but I'll join you again  
17 in the morning.

18           CO-CHAIR HOMER: Thank you Jane.

19           DR. WINKLER: Thank you Jane.

20           MS. PERKINS: Thank you very much,  
21 bye-bye.

22           DR. LIEBERTHAL: I'm glad you

1 brought up asthma and the structured  
2 questionnaires because if you ask the patient,  
3 using asthma as an example, how's your asthma  
4 doing or how's your kid's asthma doing very  
5 often you'll get the answer, oh, okay no  
6 problem.

7                   Then when you ask the specific  
8 questions, you find out there is a problem.  
9 So I would suggest that patient reported  
10 outcome needs to be by structured set of  
11 questions.

12                   CO-CHAIR HOMER: And again, are we  
13 differentiating or would we elaborate on this  
14 to include families.

15                   So again, I just think it's useful  
16 to do that and do we want to broaden, and  
17 maybe again broaden this to include other  
18 sources like teachers -- again if we're going  
19 to include school performance, for example,  
20 and then the other question is if we're going  
21 to include broader measures of public health.

22                   Now I assume that most of those

1 data are still going to be coming either from  
2 the child or from a professional's observation  
3 of them, but it isn't necessarily the  
4 clinician. I'm sorry, David and then Tom.

5 DR. CLARKE: Well one thing that's  
6 not up there, and I'm not sure if it fits into  
7 one of the other categories is the various  
8 registry databases that exist. You know, this  
9 is clearly from my experience with data  
10 audits, it's not exactly absolutist, but it's  
11 not bad.

12 And so I'm not sure whether that  
13 is kind of a separate source or if that would  
14 be under clinician observed outcome.

15 CO-CHAIR HOMER: What's the input  
16 into the registries that you're talking about?

17 DR. CLARKE: Well it's a whole  
18 bunch of data cells regarding the patients  
19 hospitalization or surgery or all kinds of  
20 data and it's usually rather than clinician  
21 it's entered by a data manager.

22 DR. WINKLER: Well I think though



1 that the data manager would get any clinical  
2 data from the patient record which is  
3 clinician generated, with the exception of  
4 things like the lab results and the vital  
5 signs and the, you know, the more objective  
6 data.

7           So in those cases, because it's a  
8 large data set would probably be a mixture.  
9 So it's not meant to, you know, this was meant  
10 to be just an idea of keeping in the patient  
11 reported outcomes as well as the more  
12 traditional objective information as well as  
13 the clinician generated information and be  
14 sure that we all want to include that.

15           Because I think being explicit  
16 when we do our call for measures would be  
17 important.

18           DR. MCINERNY: Charlie, getting  
19 back to the school business, I think as much  
20 objective data as we could get, I mean you  
21 could ask a parent of a child with ADHD how  
22 things are going in school and the parents say

1 oh just fine.

2 But, you'd really want to see  
3 what, you know, what are his marks, is he  
4 getting 80s, 90s, 60s, 50s, what and you'd  
5 have to be a little bit careful.

6 DR. WINKLER: Okay. Bonnie, I  
7 think it's your turn. Yes, I just -- I think  
8 we've introduced Bonnie Zell and Bonnie is our  
9 population health expert at NQF. And so she  
10 wanted to talk a little bit about population  
11 and see how you all think that we might be  
12 able to bring all this together.

13 DR. BURSTIN: And just one more  
14 framing piece before Bonnie starts. I think  
15 that, you know, the child health piece in  
16 particular can get fairly expansive as you  
17 begin to think about outcomes, the point you  
18 just raised for example, about, you know,  
19 grades in school.

20 So I think we wanted to have  
21 Bonnie give what's intended to be an expansive  
22 presentation, perhaps to see where the limits

1 could be and then perhaps we could think about  
2 where we're comfortable having them for this  
3 project.

4 DR. ZELL: I appreciate that. I  
5 appreciate the opportunity to talk with all of  
6 you. I mean, when you're talking about  
7 children and you're talking about health, this  
8 is child health outcomes.

9 I think it's really important for  
10 us to kind of understand what we're talking  
11 about when we're looking at different  
12 denominators. And so I will address that as  
13 I go through this presentation.

14 But just to remind us when we're  
15 talking about populations and we're talking  
16 about health, what the definition of that is,  
17 and I think that we've touched on that in many  
18 of the comments that have been said here  
19 today, what are the boundaries exactly, what  
20 exactly are talking about.

21 And because we're talking about  
22 children who's level of ability to perform is

1 influenced from the day they're born and  
2 really impacts them the rest of their lives,  
3 it's really an important issue for us here.

4           What we're often talking about  
5 when we're talking about outcomes is disease.  
6 It makes a lot more sense when we do that for  
7 adults, because adults are a lot sicker.

8           When we're talking about children,  
9 it's a very small number of children that  
10 intersect with the health care delivery system  
11 with some kind of problem. So I think that's  
12 really important for us to remember and how do  
13 we think this through.

14           We do talk about children's health  
15 when we're talking about screening and  
16 developmental milestones, but then we very  
17 quickly jump to we're only now going to focus  
18 on disease focused outcomes pretty much.

19           So when we're talking about  
20 population health, the World Health  
21 Organization states that it's more than just  
22 an absence of disease, it's gone some -- a

1 positive aspect to it.

2           And the Institute of Medicine  
3 talks about that, but I just really want to  
4 point out at the bottom here that they state  
5 explicitly that it's a shared responsibility  
6 of health care, governmental public health and  
7 a variety of actors in the community.

8           And so it's very complicated to  
9 figure out where the boundaries are when we're  
10 talking about children. Next please.

11           So I thought it would be useful to  
12 just kind of walk us through, how does health  
13 really happen and what does it mean when we're  
14 talking about individuals and then when we go  
15 to population health, because really they're  
16 one in the same.

17           Health happens one person at a  
18 time, one day at a time, one decision at a  
19 time, but within the context of where and how  
20 people live. Not all of us have the same  
21 choices.

22           So it's impacted by where we work,

1 where we go to school, where we play, where we  
2 shop. It's influenced by the socioeconomic  
3 things that we always talk about, education,  
4 income, employment determined by the access to  
5 health foods, safe environments, available  
6 transportation and health care services.

7           But it doesn't happen primarily  
8 within health care, especially when you're  
9 talking about children. And it does happen  
10 within the context, as we were talking about  
11 here a lot today in terms of preference  
12 choices, cultural, social and economic  
13 frameworks and these individuals then  
14 aggregate to populations. Next.

15           And that is the only thing that a  
16 population is, is wherever we decide to draw  
17 the boundary around individuals, whether it's  
18 racial, ethnic, disease specific, life stage,  
19 level of poverty.

20           It can be all the different ways  
21 we'd cut it within health care whether it's a  
22 system of a cross systems by a health insurer,

1 a clinicians practice, a piece of a clinicians  
2 practice, just a segment, the diabetics, the  
3 adolescents, the newborns.

4 It can be geographic region, which  
5 also has a very big impact on health or it can  
6 be health care resource utilization. Next.

7 Just an important reminder of when  
8 we're talking about the determinants of  
9 health, especially when we're talking about  
10 children, it's important to think about those  
11 determinants that have the greatest influence  
12 in how we want to consider those when we're  
13 talking about child health.

14 Health care is estimated to have  
15 an impact of 10 percent, obviously these are  
16 not hard numbers and in some studies people go  
17 as high as 40 to 50 percent.

18 But clearly, we really need to  
19 understand the behavioral patterns, the social  
20 circumstances, the environmental exposure and  
21 where it is that health care falls, where  
22 other sectors fall and how we might need to

1 work together. Next.

2 This is healthy people in healthy  
3 communities. This is IOMs look at the future  
4 of the public's health in the 21st century and  
5 it demonstrates right from the center of this  
6 diagram, the importance of the conditions that  
7 need to be addressed for health, next, and the  
8 roles that all the different sectors play.

9 This is the chronic care model,  
10 which I'm assuming everybody here is familiar  
11 with. But this is the expanded chronic care  
12 model that really places the health system  
13 within the community in which it sits. And  
14 it's really important for us to remember that.

15 There are things that we do in the  
16 health care system that do not get done  
17 outside of the health care system that are  
18 critically important.

19 There are things that are done  
20 outside of the health care system that the  
21 health system itself does not -- the health  
22 care delivery system does not specifically



1 address, but many things that we could and  
2 many areas where we overlap and opportunities  
3 that exist that we can influence those things  
4 that we often don't that we also need to  
5 consider I think.

6           And I think that it's also just  
7 really important to understand that we do want  
8 activated, informed patients and families, but  
9 also communities and community partners.

10 Next.

11           This is a driver diagram that was  
12 put together by a group in Wisconsin. I don't  
13 know how many of you are familiar with  
14 something called the Wisconsin County Health  
15 Rankings.

16           And these have been produced by  
17 the University of Wisconsin Population Health  
18 Institutes since 2003. They developed this  
19 driver diagram that if you look, there's  
20 health outcomes which looks at mortality and  
21 then self-assessed health status.

22           And then they look at the

1 different determinants divided up the way that  
2 I described them previously; the 10 percent  
3 health care, health behaviors, et cetera.

4 I don't know if you can see the  
5 fine print, probably not, but what they do is  
6 they just -- they break down what we mean when  
7 we're talking about health care. Here it's  
8 about access and quality of the outpatient  
9 care services, whether or not dental services  
10 are received, et cetera.

11 And you can obviously keep  
12 breaking all of these down, but it really  
13 emphasizes the significant impact that these  
14 other health determinant regions, health  
15 behaviors, socioeconomic and physical  
16 environment have and it goes down to the  
17 specifics to many of the things that we've  
18 been talking about here, high school  
19 graduation rates, et cetera.

20 DR. JENKINS: Was that intended  
21 for adults or for kids? I'm just curious if  
22 the breakdown is the same for kids as for

1 adults.

2 DR. ZELL: I would say this was  
3 really done for populations in general. It's  
4 a community health index, so it definitely has  
5 indicators in there for children such as  
6 things like graduation rates are in there,  
7 things about health education for teenagers,  
8 et cetera.

9 So it definitely has indicators in  
10 there. I wouldn't say that it's got  
11 everything by any means, but this is something  
12 that we're going to be working with as a  
13 beginning in the National Priorities  
14 Partnerships for the population health  
15 community health index, which is something  
16 else that we can talk about.

17 But I think what's really valuable  
18 about this process that they've done is that  
19 it's been recognized as something that is  
20 really gotten county level attention within  
21 Wisconsin, has motivated a tremendous amount of  
22 intervention, discussion and action.

1                   Because of that, Robert Wood  
2 Johnson Foundation funded them recently to do  
3 these county level rankings for every county  
4 in the United States. That will be released  
5 in February of 2010.

6                   What's important to know about  
7 these are they -- it's a very powerful process  
8 in that it has garnered a lot of attention and  
9 discussion, but when you're talking about  
10 action, everything is local.

11                   And we really need to take this  
12 county level information and understand that  
13 we need to look at this from a population  
14 standpoint, we need to bring it down to  
15 neighborhood and community levels so that we  
16 know what to do where, because doing it in a  
17 blanket fashion everywhere is not the best use  
18 of our resources we need to target. Next.

19                   So defining population  
20 relationship to health care, I thought it  
21 would be useful just to talk a little bit  
22 about how to bring population level

1 assessments into health care.

2           This might be things like querying  
3 the health care data that we have to  
4 understand populations. For instance, saying  
5 what percent of our patients have X problem in  
6 our practice and what percent are getting all  
7 the things that they need. And I'll give a  
8 couple of those examples.

9           But I -- my background is a nurse  
10 and then an OB/GYN physician for 20 years and  
11 practice at Kaiser in California and never  
12 once did we ask that question when I was  
13 there. I did not have any idea how many  
14 patients I had with a specific disease or a  
15 specific age breakdown, how many women at mid-  
16 life did I have that might need X et cetera.

17           So it's a very powerful way to  
18 just look at our own data. It's not hard to  
19 do, it's data that we're already sitting on,  
20 but it really gives us a very different view  
21 of what to do rather than waiting for just  
22 individuals to come and knock on our doors.

1                   What is it that we need to do  
2 proactively for the populations that we serve?  
3 Another is to utilize publically available  
4 data to better understand community context  
5 and populations by using some of the tools  
6 that we have now such as GIS mapping.

7                   So taking those same individuals,  
8 plotting them out on the map, overlaying that  
9 with some of the publically available data  
10 whether it's looking at asthma patients and  
11 air quality et cetera. You can do this --  
12 there's over 600 layers of free publically  
13 available data.

14                   And I'm working on some projects  
15 to do just -- that have just demonstrated  
16 incredible power. We're looking at congestive  
17 heart failure patients in one health system in  
18 Atlanta and just by asking questions that we  
19 had not asked before, we learned just amazing  
20 things such as some people had been admitted  
21 20 times in three years.

22                   But because it was just patient

1 was readmitted and we hadn't asked those types  
2 of questions. So, what was amazing to me is  
3 I posed a list of 20 questions that were  
4 really -- provided a lot of insight in how  
5 easy it was to query their data to get it.

6           It was just by ICD-9 codes and all  
7 these things would popup. So it's a  
8 different way to -- it's a different lens to  
9 look at what we do. Next slide please.

10           And then, you know, again when  
11 people talk about well that's health care,  
12 that's individual interventions versus that's  
13 public health, it's really a matter of  
14 understanding that there are both individual  
15 level strategies and interventions and there  
16 are population level strategies and  
17 interventions and how to bring some of those  
18 into health care.

19           So for instance, if you've done a  
20 query and you understand your population,  
21 whatever that -- whatever way you've cut it,  
22 you could do targeted outreach for screening

1 and follow up instead of these blast things  
2 that we do, we could really target what we do  
3 to specific segments of the population so that  
4 we can, again, utilize our resources in a much  
5 more efficient fashion.

6           Suggest available community level  
7 health care and health promotion resources  
8 targeted to specific populations.

9           Again, when we're talking about  
10 health care versus where these fuzzy borders  
11 are, there are a lot of opportunities for  
12 health care to disburse itself into a  
13 community to provide health related services  
14 that are still considered health care in a  
15 sense, but really impact health on a different  
16 level; disseminate newsletters, provide  
17 healthy recipes, partner with community  
18 stakeholders, schools, businesses and faith-  
19 based et cetera. Next slide please.

20           So, in addition to assessing did  
21 Alissa get her peak flow, her home management  
22 plan and a corticosteroids prescription, can



1 we also ask how many individuals that we care  
2 for in our practice have asthma and what  
3 percent of our asthmatic patients have had the  
4 peak flow over the last 12 months of home  
5 management plan, et cetera composite measure.  
6 Next slide.

7 I think it was really interesting  
8 some of the conversation that's happened  
9 earlier today where a lot of these types of  
10 issues came up and I just thought I would put  
11 some things up there that might give us  
12 something to think about in terms of  
13 conversation in thinking about where the  
14 boundaries are again.

15 So here's looking at prevalence of  
16 obesity among U.S. children and adolescents  
17 aged I think it says 2 to 19. And it's broken  
18 down by different ages on the bottom and it  
19 shows you what's happened.

20 This is NHANES, which is a federal  
21 program of evaluation across the United  
22 States, and it shows what's happened from I

1 think 19, I can't see it myself, but it's  
2 like, okay so 1971 and the last is the 2003 to  
3 2006 NHANES shows you what's happening by age  
4 and over time.

5           And clearly we have been, you  
6 know, we in health care, we measure BMI, we  
7 might suggest to parents and educate them  
8 about what kids should eat, educate them about  
9 exercise.

10           We might be able to check those  
11 off and get really good scores in health care,  
12 the question that we have to ask is how far  
13 out do we go and how do we work with other  
14 sectors to make sure that the conditions exist  
15 so that the things that we're suggesting are  
16 actually doable.

17           Meaning, is there access to the --  
18 let's talk about kids, in schools to healthy  
19 foods, recognizing that we're talking about  
20 health care, but if that's a concern of health  
21 care and if child health is a concern of  
22 health care, where do we draw these

1 boundaries.

2           What can we do, doesn't mean we  
3 have to necessarily be accountable for what  
4 goes on in schools, but can we have joint  
5 accountability with schools or can we work  
6 with schools to make sure that they have the  
7 meals that they need to have and the physical  
8 exercise, et cetera. Next slide.

9           This just shows what's happened  
10 over time from the NHANES 1988 to '94 and the  
11 next one which was 2003 to 2006 to again show  
12 the need to look at things from a segmented  
13 fashion.

14           This is looking at the difference  
15 between boys and girls and the difference in  
16 race and ethnicity and you can see that  
17 there's a huge difference in both. Next  
18 slide.

19           So as I already posed, should  
20 other sectors in the community that  
21 significantly influence health status in  
22 addition to health care have accountability

1 for health in their communities, and if so,  
2 how might we connect performance measures in  
3 health care with activities in other sectors?

4 A question just for us to talk about.

5           School nurses, I met a school  
6 nurse at a meeting just over the weekend who  
7 was talking about their interest in working  
8 more closely with health care, their nurses  
9 and the issue of community benefit and how  
10 community dollars are spent from hospitals,  
11 non-profits being required to spend a certain  
12 amount of money in community benefit.

13           Is there an opportunity there to  
14 think about how health care could get involved  
15 in these types of issues? Next slide.

16           Can we expand our frame, and  
17 you're working on your framework from why does  
18 this patient have this disease at this time to  
19 what population circumstances are the  
20 underlying causes of the disease incidents in  
21 this population. Next slide.

22           This is just a graphic just to

1 highlight that what we're focusing on is over  
2 on the right. So when I talked at the  
3 beginning about childhood -- the denominators  
4 we're looking at, I think it's really  
5 important that we just think about when we're  
6 talking about child health, the denominators  
7 we're talking about.

8           Because when we're talking about  
9 children in general and doing the screening  
10 and the milestones, we're talking about the  
11 entire population. When we're talking about  
12 those afflicted, we're talking about that just  
13 those on the right-hand side of the diagram.

14           And what we have been talking  
15 about a lot in general in terms of health care  
16 and health is moving us upstream towards  
17 prevention and so really trying to think about  
18 what that means operationally and what that  
19 means we might need to think about in terms of  
20 the broader issues.

21           And the importance, I think, of  
22 really emphasizing that public health network

1 meaning, public health governmental public  
2 health, that's schools, business, in a broad  
3 sense and public policy, city planning as well  
4 as the health care delivery system have some  
5 areas where they have distinct roles, but very  
6 large areas where there's tremendous overlap.

7 Next slide.

8           These are just some references  
9 that I put in here. The Association for  
10 Community Health Improvement is part of the  
11 American Hospital Association that did an  
12 excellent steering committee report on  
13 hospital's role in communities and their role  
14 in the public's health with many suggestions  
15 of what could be used, what could be done from  
16 a health care standpoint and a lot of  
17 information there about what I mentioned  
18 before using community benefit dollars.

19           The U.S. Preventive Services  
20 Taskforce is a resource that talks about  
21 community level, population level  
22 interventions that have been demonstrated

1 through science to have impact.

2           So for instance, there was one  
3 study in that in 14 out of 14 studies that  
4 demonstrated that those schools that had  
5 moderate to vigorous physical activity  
6 mandated for kids, 30 minutes, at least 30  
7 minutes a day had absolute decrease in BMI,  
8 they all had improved aerobic fitness and it  
9 went to the issue that somebody brought up  
10 earlier in terms of maximal function.

11           So there's a lot of different  
12 tools here, I thought I would just share that  
13 had a lot of different interventions, guides,  
14 ideas, et cetera. But I do think it's  
15 important when we're thinking about outcomes  
16 to think about health outcomes as well as some  
17 of the outcomes we've been focused on. Thanks  
18 very much.

19           CO-CHAIR HOMER: Thank you Bonnie.  
20 Tom?

21           DR. MCINERNY: Well of course, the  
22 Massachusetts has instituted a couple of

1 changes and I'm not sure whether they're  
2 improvements or not, but certainly universal  
3 health care for everyone and how has that  
4 affected the health outcome of children. I  
5 don't know if anybody's looked at that and  
6 where they are with that.

7           And then the other is the mental  
8 health project to divide the state up into six  
9 regions and provide consultative services for  
10 the primary care physicians and I know that's  
11 two or three years old now and I'm not sure  
12 what the health outcomes of that has been  
13 either.

14           CO-CHAIR HOMER: Two good  
15 questions. We could find out more I think  
16 short answer on the health insurance, again,  
17 we had relatively low health uninsurance for  
18 kids before the expansion, we now have even  
19 lower. I think it went from -- but it already  
20 was quite low.

21           And I think in terms of health  
22 status, I don't know. I don't think we've



1 seen the health status effect yet. Mental  
2 health is a good one, there was both that and  
3 then there's more recently what's called the  
4 Rosie D. Settlement which is an even more  
5 expansive mental health program.

6 But to be determined. We'll send  
7 Reva home to do some homework and see if -- no  
8 I don't think there are yet any measures of  
9 impact of those societal changes.

10 But those are largely, to Bonnie's  
11 point, those are largely health care service  
12 changes rather than some of the broader  
13 changes that her report was at least  
14 suggesting we bring on to the table for  
15 consideration, you know, which would be more,  
16 again to use the parochial Massachusetts  
17 approach.

18 Massachusetts also launched what  
19 they call Mass in Motion which is more about  
20 in addition to providing health services it's,  
21 you know, getting the wise involved and  
22 building more sidewalks and changing school

1 lunches and, you know, all the broader array  
2 of interventions that are going to address the  
3 particular issue of obesity. Donna?

4 DR. PERSAUD: Thank you. That was  
5 an outstanding set of slides that I would like  
6 to borrow is my first request if that's  
7 possible. I really like the integrated way  
8 that you have the concepts listed up there and  
9 all the resources.

10 And I think that I guess being the  
11 prevention minded pediatrician it's an  
12 interesting thought to come up with joint  
13 accountability for measures.

14 And if it's not even in scope for  
15 what we're supposed to do, I think we have to  
16 acknowledge that some of our limitations might  
17 be because we're not getting to joint  
18 accountability.

19 And some of what I talked to in  
20 our community care we realize that the obesity  
21 epidemic is such that the answer is not going  
22 to be find every child a doctor and get them

1 a check up every year. It's going to be joint  
2 accountability with other entities.

3 So it would be neat and maybe  
4 that's the future of this to begin to use  
5 those concepts in the conceptual framework.  
6 And I am actually coming, I don't know where  
7 we'll be doing the conceptual framework  
8 brainstorming, but I've got maybe a 3D idea in  
9 my head coming up that it's not going to be  
10 flat, it might be 2D I think there's a chance  
11 it could even be 3D.

12 DR. ZELL: Could I comment on  
13 that??

14 CO-CHAIR HOMER: Please.

15 DR. ZELL: Because I think that  
16 what you're bringing up Donna is really  
17 important that I think, and I'm not sure what  
18 the answer is, but I think we tend to try to  
19 boil things down to something very simple and  
20 linear and in fact what you're saying with  
21 three-dimensional I would call complexity.

22 It's very complex and especially

1 when you're talking about child health. I  
2 think we have to understand the complexity of  
3 it and all these different factors that  
4 interrelate and somehow acknowledge that.

5           And I think be explicit about  
6 where we're -- I mean if this group decides  
7 that it's just really health care focused on  
8 the traditional sense, I think it should be  
9 stated so explicitly.

10           DR. JENKINS: I want to echo what  
11 Donna said and thank you very much for that  
12 presentation and it was a little bit what I  
13 was alluding to before about this population  
14 based health.

15           But I guess I have a question then  
16 for Reva or Helen, again related to scope. I  
17 was making the assumption that these were  
18 going to be NQF endorsed measures of health  
19 care but I heard you say at like the very  
20 beginning that NQF also has a priority setting  
21 for health over all mission.

22           And is there anyway that this

1 process could perhaps influence that priority  
2 setting process rather than just the  
3 measurement endorsement or is that out of  
4 scope for us?

5 DR. BURSTIN: No that's very much  
6 within scope. The National Priorities  
7 Partnership has already identified population  
8 health as one of the six national priorities  
9 and within that delineate a real focus on  
10 preventive services screening, healthy  
11 behaviors and this general concept of sort of  
12 a community index of performance.

13 I think there is a very open  
14 question as to whether over time there is an  
15 expectation. Perhaps we'll get some measures  
16 for which accountability can't be solely laid  
17 at the heels of the health care system. And  
18 it may be now.

19 We've already, for example,  
20 endorsed the set of AHRQ prevention quality  
21 indicators which indicate preventable,  
22 potentially preventable admissions of a

1 community. They're community level indicators  
2 and it's very hard to specifically assign  
3 accountability for whom that, you know, that  
4 admission could be potentially related.

5           But at the same time, there's a  
6 recognition that's an important quality  
7 measure for us at the community level. So I  
8 think that's what we wanted to bring to you,  
9 get your sense of it.

10           I mean, you know, as Bonnie and I  
11 were talking about this, she clearly goes  
12 further than my comfort zone, but this is  
13 where she lives. But, you know, I think there  
14 may be measures where we were beginning to see  
15 some coalescence of some of these different  
16 sectors coming together.

17           And I think especially in this  
18 group, it's hard to imagine you wouldn't want  
19 to consider schools as a logical locus within  
20 which, at least for me it's the interstices,  
21 you know, can you at least think about  
22 measures that maybe get us closer towards

1 understanding those linkages, those  
2 connections those opportunities for  
3 collaboration that could improve kid's health.

4 DR. PERSAUD: Actually just very  
5 quickly, the last mock Joint Commission survey  
6 we had, the surveyor came in and asked us  
7 whether we assessed cognitive and academic  
8 performance of children with asthma to help  
9 them in their self-management.

10 And that would be a great example  
11 of how that circular where your health care is  
12 going to effect their ability to handle school  
13 and their ability to achieve in school is  
14 going to effect their ability to manage their  
15 medications and their asthma action plan, so.

16 DR. JENKINS: I also think laying  
17 out a complex framework is actually protective  
18 about inappropriate use of measures in certain  
19 -- at context.

20 Just to make the point in  
21 Massachusetts, we've had bitter battles with  
22 our major payer over whether or not

1   pediatricians could be held accountable for  
2   reductions in rates of obesity or whether  
3   that's beyond scope of what they can  
4   legitimately be accountable for.

5                   And so if the whole framework was  
6   laid out, it will also be protective against  
7   inappropriate use of measures. So far they've  
8   rejected the opportunity to be accountable,  
9   but just barely been able to make it through.

10                   CO-CHAIR HOMER: The thing is the  
11   payers wanted to hold the accountables -- the  
12   providers accountable --

13                   DR. JENKINS: For reductions in  
14   rates of BMIs and actual improvements towards  
15   normal and the pediatricians have marketably  
16   rebelled against having money on the table for  
17   that because they do not believe they can  
18   influence it.

19                   DR. ZIMA: This is the first time  
20   I've met another Dr. Bonnie Z. MD, MPH and  
21   it's amazing because, you know, we struggle so  
22   much in child psychiatry because how much is



1 child psychiatric care responsible for things  
2 like recidivism, out of home placement, child  
3 abuse.

4           But if you look at some of,  
5 particularly in California, the state funded  
6 legislation for mental health, those outcomes  
7 are in there. And I think one of the examples  
8 right now we have is the California Mental  
9 Health Service Act where mental health dollars  
10 are being justified to reduce things like  
11 homelessness.

12           So I think that, you know, from a  
13 psychiatric perspective, this whole idea of  
14 joint accountability, we desperately need some  
15 help because right now we are using mental  
16 health dollars with the assumption we're going  
17 to improve those outcomes.

18           CO-CHAIR HOMER: I personally  
19 think that's certainly in our scope to at  
20 least -- I think we definitely need to look  
21 broader than just academic performance, but  
22 look at those issues like recidivism and like,

1 you know, jail rates or whatever the --  
2 incarceration rates, that's the word I was  
3 looking for and those to violence, youth  
4 violence, a variety of things that are outside  
5 the typical scope.

6 DR. ZELL: Has everybody else had  
7 a chance?

8 DR. WINKLER: I think one of the  
9 things that when we do this call for measures  
10 when we look at potential measures out there,  
11 considering the population focus, if you look  
12 at the measures we've already endorsed, there  
13 are quite a few of them who's denominators are  
14 per 100,000, all right. So certainly NQFs  
15 been down that road before.

16 And the question would be, you  
17 know, to what entities can that be applied?  
18 Does it have to always be geographic, which is  
19 sort of the traditional, but could you apply  
20 that to a large health system? Could you  
21 apply that to a health plan? Maybe not the  
22 smallest, but the other, so and why not.

1           So that it's sounding, from your  
2    comments, that the kinds of measures, the  
3    kinds of what we call population measures  
4    where you have the denominator is something  
5    like per 100,000 or per 1,000 or something  
6    like that, would be measures you would want to  
7    consider.

8           Would you want to keep in the box  
9    as opposed to exclude them, though they will  
10   have their limits and their applicability can  
11   only be, you know, might be different than  
12   some of the more traditional ones.

13           But are these important outcomes  
14   that we need to have within our framework and  
15   within our set or our hoped for set, or our  
16   ideal set? Yes, yes, yes? No, no, no?

17           DR. ZIMA: It's interesting  
18   because I think that it depends on who's  
19   paying as far as sort of, you know, the  
20   outcome that we want to improve.

21           I think, you know, Medicaid public  
22   mental health it's a little bit easier to go

1 down that slope because it's all public  
2 dollars and then we talk about cost shifting  
3 and that we've kind of justified mental health  
4 services because we ideally reduced cost and  
5 probation or something like that.

6           But I don't know -- I mean it  
7 raises sort of another level of complexity  
8 about when the responsibility in a privately  
9 insured company is not owning responsibility  
10 for the societal outcomes.

11           DR. WINKLER: But wouldn't they be  
12 responsible for their population of enrolled  
13 or folks that are part of their system as a  
14 population.

15           And that I think was a lot of what  
16 Bonnie was talking about was, you know, not  
17 just who walks through the door, but if  
18 they're part of your group, define the group  
19 however you want, but if their yours, do you  
20 have accountability for the entirety of the  
21 group and not just the active ones?

22           DR. ZIMA: I think that's a good

1 question.

2 DR. PERSAUD: I think what you  
3 said with, you know, as long as we define the  
4 limits of applicability of the measures and I,  
5 just speaking as an end user and knowing  
6 what's going on in the communities, I do think  
7 more and more coalitions and communities want  
8 to galvanize resources around what should be  
9 the benchmarks.

10 And I think I'm hearing, and I am  
11 one of the needers of those kinds of measures,  
12 but I do think we should be very prudent about  
13 defining the applicability and the  
14 reasonability to, you know, who's using it and  
15 why.

16 CO-CHAIR HOMER: Do we want to try  
17 come up with a threshold, I mean it's -- there  
18 are no data on this, but do we want to come up  
19 with some threshold of proportion of, you  
20 know, attributable risks or accountabilites.  
21 So for example, your BMI in Massachusetts, you  
22 know, could we reasonably attribute to the

1 health care sector, you know, X proportion of  
2 accountability?

3 I mean, on the smoking -- so for  
4 example, on the smoking issues on the adult  
5 side, so for example, obviously people are --  
6 plans are held accountable for counseling  
7 about smoking cessation, are they held  
8 accountable for the proportion of the  
9 population that smokes is I guess the next  
10 questions.

11 I mean, that's a held behavior. I  
12 mean that's the kind of stuff, never mind lung  
13 cancer rate as a preventable outcome measure.  
14 Because I think that would probably be along  
15 the lines of what we're talking about.

16 DR. RAO: How about some case  
17 studies as to how each measure should be used,  
18 like a little paragraph that follows them.  
19 For example, you know, smoking rates in this  
20 health plan happen to be this much, this is  
21 what the health plan actually did to change  
22 them or to enforce them in a positive way.

1                   CO-CHAIR WEISS: I honestly I'm  
2 seeking information here, I honestly don't  
3 know the answer to this. Are there studies  
4 that we could look to that would give a sense  
5 of what compliance rates for various of these  
6 measures would be? Average by cutting it by  
7 type of population or region or whatever?

8                   DR. WINKLER: Marina, one of the  
9 things we ask for in the measure submission is  
10 that sort of data. And even those that  
11 provide us with a large amount of data  
12 actually it's relatively limited to -- your  
13 question was extremely expansive.

14                   I mean I'd love to have, you know,  
15 wide ranging data on all sorts of things and  
16 stratify them in a 1,000 different ways, but  
17 that's very rarely available. So to the  
18 degree data is available, usually whoever the  
19 measure developer is, they're using it for  
20 whatever their purpose in developing the  
21 measure was and they will have applied it to  
22 that group.

1                   Sometimes it's big, and sometimes  
2 it's very narrow and it tends to be somewhat  
3 variable. Whether there's additional  
4 information, except in some of the large  
5 measure developer activities where they  
6 publish as a result of some of it, it's really  
7 hard to find. And if you all can help us with  
8 that, that would be grand.

9                   DR. RAO: But Reva isn't one of  
10 the criteria for submission -- a basic  
11 criteria for submission of a measure is that  
12 they have to identify a significant problem?  
13 You can't put in a measure, for example, where  
14 everyone's, you know, giving out influenza  
15 immunizations already sort of --

16                   DR. WINKLER: Well they can submit  
17 it, but it should fail on, you know, some of  
18 the criteria in terms of usability, in terms  
19 of importance around is there a gap and  
20 variation in care, is there a quality problem  
21 associated with it. So they can submit, but  
22 it would have struggles against some of the



1 criteria.

2 CO-CHAIR WEISS: Well let me just  
3 suggest then that maybe we would like to think  
4 about this by changing the paradigm a little  
5 bit and maybe instead of looking for someone  
6 to hold accountable in these areas where it's  
7 an entity, an organizational entity to hold  
8 accountable where it's iffy, maybe we put this  
9 issue of measuring true outcome in the basket  
10 of items on which we would like to see  
11 additional work done, I mean.

12 DR. LIEBERTHAL: Charlie mentioned  
13 the idea of apportioning to the health care  
14 system part of the outcome and I think that's  
15 a very slippery slope because I don't think  
16 there's any way to collect data that would be  
17 applicable.

18 However, in using outcome data for  
19 things that are primarily health care related,  
20 take asthma, again, using the asthma example,  
21 by comparing organizations or health care  
22 systems against one another, if they're large

1 systems and using risk adjustment factors that  
2 may be quantifiable, it's the comparison that  
3 becomes the measure.

4           So, for example, Kaiser with its  
5 asthma rates and we do have, Bonnie, I don't  
6 know when you left -- were you in Northern or  
7 Souther Cal? Northern. I think you have some  
8 of the same systems as we have, but we have  
9 some very robust systems for measurement,  
10 population measurement that can be broken down  
11 by medical center office, provider, et cetera,  
12 et cetera.

13           How we use them is another story  
14 for using them robustly or not. However, if  
15 you have a measure that is a valid measure and  
16 you put the Kaiser Health System up against  
17 United Health Care and against Blue Cross, et  
18 cetera, et cetera, now you have a comparison  
19 against which health care organizations can be  
20 compared.

21           And then if you make this public,  
22 as is done with HEDIS measures, you now have

1 a basis for consumers to pick the health care  
2 so the incentive is if you do well on the  
3 measures then you will be more successful in  
4 an economic and business sense.

5           You could even stretch this to  
6 school systems again using the adjustment,  
7 what is the obesity rate in a school system  
8 and what should a school system be doing to  
9 deal with the education or break up any  
10 comparable populations and compare them  
11 against each other. So this is one way that  
12 measure, outcome measures could be used.

13           DR. BURSTIN: Just one additional  
14 thought, this is really interesting. If you  
15 actually look through the National Priorities  
16 Partnership and you go to the population  
17 health goal, for example, the goals themselves  
18 are quite broad and intended to be so.

19           So the three under population  
20 health is all Americans who receive the most  
21 effective preventive services recommended by  
22 the taskforce, all Americans will adopt the

1 most important healthy lifestyle behaviors  
2 known to promote health and the third is the  
3 health of American communities will be  
4 improved according to a national index of  
5 health.

6           So they are far reaching and  
7 that's the intent. And I think what we're  
8 trying to get at is, there may be a set of  
9 measures that are the best measures we need to  
10 move the nation's health.

11           I think what you're kind of  
12 getting at Kathy is there are issues where the  
13 accountability locus isn't always clear and  
14 assigning accountability can be complicated,  
15 but it may still be that a measure that looks  
16 at the reduction of obesity in a community or  
17 in a accountable care organization or in a  
18 public health system is very appropriate.

19           But I think the key thing is  
20 thinking about what the appropriate level  
21 locus of accountability is, but still the  
22 right measure we should endorse should still

1 be the one that gets us to the right place.

2 DR. ZIMA: So question, because I  
3 think when we talk about joint accountability  
4 there's also that whole problem with data  
5 sharing and data linking across the sectors.

6 So in thinking, you know, when you  
7 say, okay that's a future research agenda  
8 item, when we start thinking about the  
9 measures, should we also be identifying other  
10 data sources that would require linking in  
11 order to measure that outcome?

12 CO-CHAIR HOMER: We have the  
13 privilege of not actually having to develop  
14 the measure. We don't do any measurement  
15 development here, so we -- but we do need to -  
16 - I think the question is, who would we be  
17 soliciting and eliciting measures from?

18 DR. ZIMA: It's an exercise  
19 because it nicely kind of stimulates I think,  
20 you know, Marina says, okay let's put that on  
21 sort of the future agenda, you know, that  
22 these are things that we think are important

1 like recidivism or reduced foster care  
2 placement.

3 But is that within the scope of  
4 this committee to sort of at least identify  
5 that oh, that would require data linking that  
6 right now existing health care data bases  
7 aren't allowed to do for HIPAA or whatever?

8 CO-CHAIR HOMER: I mean again,  
9 typically what would happen would be we could  
10 identify a whole bunch of things and then  
11 either ourselves opine about what would be  
12 needed for it or that often would lead NQF to  
13 create some workgroup that's going to  
14 elaborate on that. I think that's what  
15 happened on the care coordination process.

16 CO-CHAIR WEISS: Another way we  
17 might go, for example, is to do a spreadsheet  
18 and on the far right column say, this  
19 particular measure lends itself to a  
20 population wide reporting system. So we could  
21 flag it and say this has -- this particular  
22 measure has added value in the population wide

1 arena.

2 CO-CHAIR HOMER: Why don't we take  
3 the two questions that are on the floor and  
4 then I think we're due for a break. So Tom  
5 and then Lee.

6 DR. MCINERNEY: On the population  
7 thing, I think one of the most important  
8 lessons that we need to get across to  
9 physicians and providers is to measure the  
10 health of their entire population of patients.

11 All too often, you know, we ask  
12 the physicians, you know, how's your  
13 immunization rate, oh it's great, 90 percent  
14 of my patients are immunized. But then when  
15 you ask them to actually go and look at all  
16 the patients that are in their practice, oh  
17 gee, you know, these kids, I don't see these  
18 kids very often and they don't have a very  
19 good immunization rate.

20 And then all of the sudden, whoa.  
21 And unfortunately, it's the rare practice, in  
22 my experience unless maybe in Kaiser or some

1 other program like that, that has a clue of  
2 how many patients they have and how well  
3 immunized or how many patients with asthma  
4 they have even and how well they take care of  
5 them.

6           You know, if you ask a  
7 pediatrician name all your patients with  
8 asthma, they can come up with three or four  
9 and then they start to wonder, gee I don't  
10 know.

11           And that's a big, big problem and  
12 I think trying to get that message across that  
13 you are responsible for a population of  
14 patients that are registered with you and you  
15 really have to know what's going on with all  
16 of them and have to reach out to them in some  
17 way, that would make I think, may make one of  
18 the bigger differences on population health.

19           CO-CHAIR HOMER: And again,  
20 because the audience for NQF is broad and may  
21 of the users are plans who actually do have a  
22 defined population and efficient practices,



1 but it's good. Lee?

2 MS. PARTRIDGE: I'm just feeling a  
3 little confused. Are we talking in the  
4 population health context of inviting outcome  
5 measures be submitted for our consideration  
6 that are things like incidents of carries  
7 among -- of children under the age of 12, is  
8 that what we're talking about? Because we get  
9 -- I think we're going to get a lot. Well,  
10 whatever.

11 CO-CHAIR HOMER: I said then that  
12 will slide us very quickly to the Healthy  
13 People 2020.

14 MS. PARTRIDGE: Well yes, it kind  
15 of looks like that. And yet I absolutely  
16 appreciate the relevance of some of that kind  
17 of data for galvanizing activity in the health  
18 community and in the community at large.

19 I mean I picked the dental one  
20 because it happens to be a very difficult one  
21 with respect to low income populations. And  
22 if you -- except in the state of Oklahoma

1    which -- I mean Utah, which bars fluoridation  
2    of water, it's usually an indication of lack  
3    of access.  But I just wondered how big are we  
4    here?

5                   DR. WINKLER:  Well ultimately  
6    that's the question we're posing to you and as  
7    Lee mentioned, if we don't put reasonable  
8    boundaries, we're getting more than we can  
9    handle.  So trying to find where those  
10   reasonable boundaries are for the work and the  
11   people and us to do in the time frame is the  
12   realities we have to deal with.

13                   There's a lot -- there are tons of  
14   things you can do, but the question is how do  
15   we define it in a way that is appropriate, but  
16   doable.  And so I'm not the one to answer that  
17   Lee, you are.  But it's a very appropriate  
18   question to put out for folks to consider to  
19   help us define where the edges are, where the  
20   boundaries are.

21                   CO-CHAIR HOMER:  So what I'd like  
22   to do is to call for break and give us a 15

1 minute break. Let you mull on these as well  
2 as return a few phone calls and use the  
3 facilities. We'll return in 15 minutes and  
4 then try to come to some level of closure  
5 around this topic.

6 (Whereupon, the foregoing matter  
7 went off the record at 3:14 p.m.  
8 and went back on the record at  
9 3:44 p.m.)

10 CO-CHAIR HOMER: Well we gave you  
11 a little more time during the break so that  
12 you could figure out all the answers in your  
13 small group discussions and come back to the  
14 group with it. Again, my sense from the  
15 previous discussion was productive and broad  
16 ranging conversation.

17 I detected a fair amount of  
18 enthusiasm at one level for considering broad  
19 measures of population impact with an  
20 undercurrent of anxiety about both the  
21 accountability and the flood gates that that  
22 could open in terms of the response. That's

1 kind of my take on that conversation.

2           So I think what we need to do is  
3 come to some closure in the next 45 minutes or  
4 so with what we would like -- what we'd really  
5 like to put as the scope of the call for  
6 measures.

7           And one thing maybe to start with,  
8 was it -- who had said they had in their mind  
9 a multi-dimensional matrix?

10           CO-CHAIR WEISS: Donna.

11           CO-CHAIR HOMER: Donna. Did you -

12 -

13           DR. WINKLER: 3D.

14           CO-CHAIR HOMER: 3D, would you  
15 like to start without putting you on the spot,  
16 would you like to start by framing that up?

17           DR. PERSAUD: So I'm drawing over  
18 here in looking at Bonnie's slides. I guess  
19 what I'm kind of thinking is that growth and  
20 development might be the permeating concept  
21 across many measures.

22           And I'm starting with this one

1 sentence in one of the early documents that  
2 says in the most global sense that a child --  
3 a health child is one who has transitioned  
4 well from fetus to adulthood. And I like that  
5 transition because I think that that's very  
6 foundational for pediatrics.

7           That's what the development  
8 defines as separate than all other speciality  
9 lines, probably development and family.

10           And so I'm thinking that I would  
11 like to have growth and development somehow  
12 permeate through all the measures, at least on  
13 an assessment level that when we're looking at  
14 them we're in or out; are you, you know, does  
15 this measure for ADD, for asthma where's  
16 growth and development.

17           So that's sort of one trajectory  
18 going on. And then the other is that there's  
19 growth and development one way, but at any  
20 point while you're growing, whatever's going  
21 on around you in the environment is affecting  
22 your ability to make that transition, right,

1 whatever is going on in the school, public  
2 policy, media, et cetera.

3           And where I am is so how does this  
4 10-40-40 rule fit in, which is the 10 health  
5 care, 40 behavioral, 40 or 30 genetic. And  
6 those three constructs are in my head as, you  
7 know, what's the way to graphically represent  
8 those constructs.

9           And the last point I have in my  
10 head is that let's maybe not try to be  
11 perfect, but come up with something that we  
12 think makes best sense that we can all live  
13 with, but that is somewhat forward thinking  
14 and might help to move the profession forward  
15 in terms of being able to accept and deal with  
16 the complexity because I think that in part  
17 what's going on.

18           There's a depth of growth and  
19 development and then there are the snapshots  
20 going on of what is the context of the  
21 community and the individual versus  
22 population. So, I think after I sleep on it

1 I might have some kind of drawing. But that's  
2 my thought.

3 CO-CHAIR HOMER: Any other  
4 thoughts how to build on that? Tom?

5 DR. MCINERNEY: Well I think it's  
6 always a good idea to sort of think about who  
7 our audience or customers and I guess  
8 certainly HHS and CMS would be kind of the  
9 national level and then I think about health  
10 plans, the insurers or health systems, again,  
11 going down one more level and then eventually  
12 down to providers, you know, provider systems,  
13 practices, which is a smaller level.

14 All of those people will  
15 presumably -- the measures will be -- they  
16 will be applied to them or they may want to use  
17 the measures one way or the other. And so we  
18 need to think about making measures that are  
19 useful at those various levels.

20 CO-CHAIR HOMER: Agreed. So the -  
21 - I wouldn't say tension, but I love the idea  
22 that we're going to move things forward and be

1 forward looking. I think we should also  
2 realize that for this to be picked up and used  
3 probably should build on some of the  
4 reasonably successful frameworks that are out  
5 there.

6 I mean Kathy you already mentioned  
7 the STEEEP one, safe, timely, effective,  
8 efficient, equitable and of course we should  
9 call it STEEEF because it should be family  
10 centered. So that's one framework and I think  
11 we should be cognizant of that and use that as  
12 a potentially dimension.

13 I mean another one, just to state  
14 the obvious, but it's the acute care, the  
15 chronic care, the preventive care and much of  
16 what we talked about was preventive care.

17 And sometimes with the fact  
18 framework they use sort of palliative or end  
19 of life care as the other dimension or  
20 sometimes even transitions. I think maybe as  
21 a euphemism that they use but maybe for us  
22 transitions might have a broader framework.



1                   I think we shouldn't shy away -- I  
2 mean from an age based -- I mean the easy way  
3 to force the capture of developmental issues  
4 is to say deal with age and again it makes  
5 sense to at least get people to think about  
6 measures and basically the usual categories.  
7 I mean, infancy, preschool and we can argue.

8                   But, you know, base is zero, one,  
9 you know two to five, school age which is 6 to  
10 12 more or less and then adolescence, which is  
11 13 to I better say 21 or the AAP and NACHRI  
12 and all those other people will shoot me. So  
13 we should write the AAP certainly. Those  
14 would be reasonable things to do.

15                   We need this developmental  
16 context. I mean before I saw your list of  
17 outcomes, I mean I was in clinical, functional  
18 experience of care and then developmental with  
19 the usual cognitive, emotional, social and  
20 physiologic characteristics.

21                   So those are lots of dimensions,  
22 but I don't -- I think it is a complex world

1 and I don't think we can shy away completely  
2 from that complexity. Kathy?

3 DR. JENKINS: What I'm wondering  
4 about and I keep thinking back a little bit to  
5 some of Bonnie's slides if in terms of an  
6 overall depiction there was some slide where  
7 there was the community, contextual, the big  
8 cloud with all the complexity and then the  
9 blue got like a little bluer and it kind of  
10 focused down more towards the health care  
11 component.

12 And that was a good one too, but  
13 the combination of the triangle one plus the  
14 cloud one, but that one --

15 CO-CHAIR HOMER: The chronic care  
16 model, yes.

17 DR. JENKINS: Chronic care model,  
18 okay sorry I thought she just made that up.  
19 But anyway the point was that I was thinking  
20 was we could put out a call for both kinds of  
21 measures wherefore the broader blue asks  
22 specifically for population based measures of

1 overall child health that could potentially be  
2 useful to guide public policy around improving  
3 the health of children.

4           And an interesting framework for  
5 that might be something like the multi-  
6 dimensional WHO definition of health or  
7 something comprehensive.

8           And then for the health care  
9 system, ask explicitly for measures related to  
10 child health that have a high component of  
11 actionability and attribution by the health  
12 care delivery system.

13           And then I'll go back to what I  
14 said before which is we have found, and I must  
15 say one of my colleagues kind of put this  
16 forward how incredibly helpful it's been to  
17 use the Institute of Medicine six steps  
18 towards high quality care. It's just worked  
19 way better than I ever thought it would to  
20 hang the ornaments on the tree.

21           But just so you know what we found  
22 is that for many of the criteria we could find

1 whole system type measures, but for the  
2 effectiveness domain we had to go one disease  
3 at a time and we could never get away from  
4 that.

5 CO-CHAIR HOMER: And I was just  
6 going to say, the National Quality Report  
7 certainly uses those dimensions matrix with  
8 basically \*\*\*3:54:32 and the fact, you know,  
9 living with illness, getting better, staying  
10 healthy, end of life care framework.

11 So I think that for the health  
12 care setting with a developmental context I  
13 think would probably work reasonably well. I  
14 personally like your idea of soliciting that  
15 as a distinct -- right, soliciting both but  
16 articulating it as a distinct call or a  
17 distinct component of the call and considering  
18 those kind of as a group.

19 DR. WINKLER: Two, sort of more  
20 two types of things to differentiate them so  
21 that people don't get muddled.

22 MS. PARTRIDGE: But Reva, where

1 the developer can point to specific links  
2 between the two, that will certainly  
3 strengthen their position vis-a-vis our  
4 judgement, right?

5 DR. WINKLER: In terms of the  
6 population measures, I mean we're still  
7 talking the context of outcomes, right? Yes,  
8 okay, just making sure. Just checking. Let's  
9 not range too far, there's only five of us.

10 DR. BURSTIN: I just want to make  
11 one other point actually just to give you  
12 some, perhaps some comfort. When the measures  
13 actually come to us they all have to complete,  
14 and Kathy knows this, a very detailed measure  
15 submission form.

16 And so they're going to already  
17 have to up front indicate the level of  
18 measurement or analysis for the measure. And  
19 so that could be individual clinician,  
20 facility, intermediary delivery system, health  
21 plan or community or population.

22 So just to keep your mind -- so

1 there may be measures that will come in that  
2 will be very appropriate or community  
3 population level like those preventable  
4 quality indicators we endorsed through AHRQ,  
5 but there may be some that would fit better at  
6 the clinician level.

7           So you can have the wide range and  
8 specifically indicate that this level of  
9 analysis can be a very important consideration  
10 for the steering committee as those measures  
11 come forward.

12           CO-CHAIR HOMER: And the  
13 importance criteria specify the link to the --  
14 I mean they will have to at least articulate  
15 how there's a link between health care  
16 delivery and broader outcomes.

17           DR. RAO: Reva, just a question.  
18 In the past for measures have individual  
19 clinicians just submitted measures even if  
20 they're not affiliated with the organizations?

21           DR. WINKLER: Yes, it's not he  
22 most usual, but yes occasionally, often

1 academics. Kathy are you an individual when  
2 you submitted yours?

3 DR. JENKINS: We submitted on  
4 behalf of Children's Hospital Program for  
5 Patient Safety and Quality. But I do know  
6 that other people have just worked hard to  
7 make a good definition and send it in. I  
8 don't know how it's been received at NQF.

9 DR. WINKLER: It's not the most  
10 common, but certainly there's no reason not to  
11 do that if you know somebody who's doing some  
12 good work. What we're planning on doing is  
13 all the things you've brought up today, we're  
14 actually going to spend the rest of the  
15 evening looking for some of this stuff, we're  
16 going to bring it back to you tomorrow.

17 Hopefully we'll have some of these  
18 lists and some of these ideas for you to refer  
19 to. The things you've brought up in terms of  
20 I'm going to remake that one slide with your  
21 recommendations, we'll see as sort of a next  
22 draft, I mean you can play with it again, and

1 we'll see if it's working for you.

2           We'll, you know, try and develop  
3 some draft or rudimentary ideas of how we  
4 might combine some of these dimensions in  
5 terms of plugging in some of the existing  
6 measures and how -- and see how that might  
7 work for you.

8           One of the problems is, the only  
9 way we can display it is two-dimensionally so  
10 we might have to think creatively and sort of  
11 in your mind build the third dimension or the  
12 fourth dimension or whatever dimension you're  
13 working in.

14           But we'll see if we can kind of  
15 draft up some of these to give you a sense of  
16 what these might look like and see how you  
17 react to them.

18           And that's what the plan for kind  
19 of tomorrow morning is, see if we can organize  
20 some of your thoughts into, you know, what  
21 we've heard and kind of format it up for you,  
22 give it back to you and give you a chance to



1 say that's not really what I meant, maybe it  
2 sounded good but didn't really look so good  
3 now, can you do this, that or the other thing.

4           So it's a working together to get  
5 some of your immediate feedback. But we will  
6 be looking to draft the call for measures, you  
7 know, the meat of that and as well as this  
8 sort of framework idea of creating a way to  
9 describe what we're looking for in child  
10 health outcomes.

11           And we'll use as examples the  
12 existing endorsed measures to plug in there  
13 and ask, you know, is this working, plus the  
14 idea of let's flag the population health  
15 measures, we can see if we can do that, we can  
16 give them a gold star or something and see if  
17 we can put some of these into play and see if  
18 this is working for you.

19           If not, we can, you know, we can  
20 go to plan B or something. So what you've  
21 done today actually has given us the tools to  
22 try and synthesize it a bit to present to you

1 tomorrow to allow you to refine it, revise it,  
2 scrap it and start over, whatever it is that  
3 works for you as part of this entire process  
4 of you guys being able to present this not  
5 only to yourselves, but to a greater audience  
6 to understand how an approach for looking and  
7 measuring child health outcomes.

8           So questions about where we're  
9 going?

10           CO-CHAIR WEISS: I have one quick  
11 question. Tomorrow when you present to us  
12 Reva, is it your thought that you would lay  
13 out kind of a draft of the call for measures,  
14 is that the idea?

15           DR. WINKLER: Certainly the meat  
16 of it, you know, there's all sort of  
17 boilerplate that goes fore and aft, but yes,  
18 the actual we are looking for measures that.

19           CO-CHAIR WEISS: Right. I've got  
20 sort of two suggestions that I just want to  
21 offer up and they just may be redundant to  
22 what you're thinking already, in case not.

1 The first is to make it abundantly clear in  
2 the title that outcomes is the focus and then  
3 to define right up front what we mean by  
4 outcomes or whatever you think needs to be  
5 taken into account in making that judgement  
6 call.

7 DR. WINKLER: Okay. Other  
8 suggestions? Now's -- jump in.

9 DR. MCINERNEY: More of a question.  
10 When you send out the call for measures,  
11 typically from what organizations do you get  
12 responses?

13 DR. WINKLER: It really is across  
14 the board. I think this summer we pulled  
15 together all the measure developers who've  
16 submitted measures over the years, we're  
17 trying to update their information on how --  
18 and working with us.

19 And it's over 75 organizations  
20 that are currently on our list, but we know  
21 there are others, especially in specialty  
22 areas like children. There might be folks out

1 there that we really haven't, for whatever  
2 reason, come in contact with and that's why  
3 we're looking to you, all for your context out  
4 in the child health community.

5           So, but, you know, we do a lot of  
6 work with NCQA, we do a lot of work with the  
7 Physicians Consortium, the Joint Commission,  
8 who else is doing them, STS has been a lot of  
9 our measures, CMSs, NACHRI has done some, I  
10 mean, you know, AHRQ, those are the big ones.

11           But we've had some, I mean like  
12 Charlie said, he's got one of the measures on  
13 BMI is from NICHQ and so sometimes it's only  
14 one or two measures from an individual  
15 developer.

16           So, you know, it's across the  
17 board, but we're always looking to increase  
18 our list so that whenever we put out a call,  
19 we send it to that group as well, and you  
20 know, we just want to keep building that list  
21 to stay in touch with all the folks out there  
22 who could be in the measure development

1 business.

2 DR. SCHWALENSTOCKER: Reva, I  
3 think sometimes I've seen you put sort of an  
4 advance notice that you'll be putting out a  
5 call for measures, and I just wonder if that  
6 might be an option here --

7 DR. WINKLER: Yes.

8 DR. SCHWALENSTOCKER: -- thinking  
9 about these might be harder measures to find.

10 DR. WINKLER: Well, yes actually  
11 it's become fairly recently, but part of the  
12 process to issue an intent kind of call, sort  
13 of a flagging, yoo-hoo out there we're doing  
14 this and ask them to just send in the list so  
15 we have a sense of what we're working with,  
16 you know, to give us some sort of forewarning.

17 We're only getting a fraction of  
18 the ones that actually end up being submitted.  
19 I mean we ended up with 14 on the intent for  
20 the main call and we got 50 measures  
21 submitted.

22 So, you know, but you're right.

1 To the degree that we can, you know, broadcast  
2 this information and we're due to issue that  
3 intent in December, it's got to be. So we'll  
4 be doing that.

5 DR. SCHWALENSTOCKER: Yes, I'm  
6 just thinking it may not be so much that  
7 you'll get that initial list, but you get --

8 DR. WINKLER: But the information  
9 is out.

10 DR. SCHWALENSTOCKER: -- people  
11 thinking ahead of time and a chance for us to  
12 use, you know, whatever vehicles we have to  
13 disseminate information, repeated messages.  
14 So it might be a way to go.

15 DR. WINKLER: Yes, no that's  
16 great. Thanks Ellen. Absolutely.

17 DR. CLARKE: Is risk adjustment  
18 part of the submission if appropriate?

19 DR. WINKLER: Yes.

20 CO-CHAIR HOMER: Yes.

21 DR. WINKLER: Absolutely. Kathy's  
22 had experience submitting a measure and it's

1 very, very detailed over all the measure  
2 evaluation. What we'll do is bring you to  
3 project sort of an example of a measure that's  
4 been submitted.

5           The way we've got it set up is  
6 with the electronic submission now it merges  
7 into the evaluation form, and we'll bring you  
8 an example of the evaluation form that you're  
9 going to see and it sort of sidebars where you  
10 can, you know, evaluate it.

11           But there's the criteria and then  
12 what the measure -- the information submitted  
13 by the measure developer right underneath it  
14 to address it. And you'll decide, does this  
15 meet that criteria or not, but the two are  
16 paired.

17           And it's very detailed, I mean  
18 those, each of those run what 10 page or so.  
19 I mean the subcriteria under each of the four  
20 main criteria are fairly extensive.

21           DR. JENKINS: The only other  
22 framework that I could think of that might be

1 helpful to make, I don't know, but to make the  
2 link between these population based measures  
3 and the actionable by the health care system  
4 measures is I think something that IHI has  
5 developed. I saw Maureen.

6 CO-CHAIR HOMER: The triple aim  
7 framework?

8 DR. JENKINS: I'm thinking, you  
9 tell me because I saw it awhile ago, it's just  
10 always been in my mind, about moving the big  
11 dots and that one of the ways to move the big  
12 dots is to have everyone know what the big  
13 dots are and then basically elaborate  
14 precisely how their actions will contribute to  
15 moving the big dots.

16 In this case obviously to what  
17 extent do the population health measures be  
18 able to be moved through action through the  
19 health care system is the obvious link, but  
20 for the community or other groups that might  
21 also want to move those population health ones  
22 that could be helpful. It's not ringing a



1 bell?

2 CO-CHAIR HOMER: No, it absolutely  
3 is ringing a bell.

4 DR. JENKINS: It was a whole talk  
5 on how do you move the big dots and strategies  
6 to do that, it's really about alignment.

7 CO-CHAIR HOMER: Yes, it's about  
8 alignment. So again it's just -- I mean the  
9 idea in part is how to move quality  
10 improvement away from doing these small  
11 isolated cool little projects to having a  
12 strategic aim and aligning your projects with  
13 a strategic aim.

14 So the way that the thinking has  
15 evolved has really turned into that driver  
16 diagram, I mean that driver diagram is meant  
17 to reflect and that's what the IHI and other  
18 groups are using.

19 It's sort of a logic model, but  
20 the idea is those are each the drivers that if  
21 you -- the ones to the right are basically the  
22 small dots, the small activities that would

1 then lead to the larger dots.

2           So I do think that that would be a  
3 useful way for us to -- could be a way to  
4 actually graphically present either in the  
5 call for proposals or help us organize when we  
6 get these things in.

7           If this is the outcome we want to  
8 achieve, which is perhaps kids being healthy  
9 and ready to work and live and things like  
10 that, and what would be the different  
11 components that would lead us to getting  
12 there, which could include the community  
13 outcomes and the clinical -- I mean I'm just  
14 thinking off the top of my head.

15           So I think that's the connection  
16 between the big dot, the driver diagram and  
17 where we are here. It's good. I can send you  
18 the slides with the big dots.

19           CO-CHAIR WEISS: The one thing  
20 that we haven't brought into the equation here  
21 though is the earlier point that you made,  
22 Charlie, about the education performance of

1 the children. Is this something that we would  
2 like to tell Reva or Helen about what we'd  
3 like to see either in the initial introductory  
4 remarks about the call for measures or?

5 CO-CHAIR HOMER: Well I think that  
6 would be included in those broader measures of  
7 community outcomes, I think.

8 CO-CHAIR WEISS: So maybe as a --

9 CO-CHAIR HOMER: As an example.

10 CO-CHAIR WEISS: -- parenthetical  
11 example or something of that nature?

12 DR. CLARKE: I'm just wondering is  
13 part of our task also taking the next step in  
14 terms of how a particular measure can be used  
15 to evaluate health care performance?

16 DR. WINKLER: Typically NQF does  
17 not get into that very deeply. In terms of  
18 the implications on potential use as it  
19 influences how you evaluate the measure, we  
20 can't draw hardline on it because a lot of the  
21 evaluation is around feasibility and  
22 usability.

1           So you can't totally disassociate,  
2 but we have no control over how it actually is  
3 used. Recommendations that go along with it,  
4 sure. Leverage, not a lot necessarily. But  
5 if you think they're important aspects, and I  
6 think the one that could be particularly  
7 useful is reinforcing the level of analysis  
8 for which the measure was developed and  
9 intended to be used.

10           Again, we have no control over  
11 what goes on out there, but making that clear  
12 that you're evaluating it for use at, it's  
13 only going to be used -- this measure is only  
14 good at the health plan level or for  
15 sufficient populations of a large enough size,  
16 blah, blah, blah and isn't intended for  
17 smaller levels of -- lower levels of analysis  
18 or smaller populations, you know.

19           I think to state that is very  
20 reasonable because you've done the evaluation  
21 of its technical merits and a lot of this is  
22 the technical aspect of sample size and all of

1 that.

2           So to that degree I think it's  
3 reasonable to make those comments, but there  
4 is just, you know, these measures get used in  
5 a whole wide variety of fashions so we can't -  
6 - and I think that's part of the -- something  
7 to keep in mind is NQF endorsed measures are  
8 used in a variety of ways.

9           But typically on the high level of  
10 accountability whether it's publishing it on  
11 a website or in a payment incentive program or  
12 in a, you know, who's in and who's out of a  
13 network situation. So significant levels.

14           So you want to keep that, that  
15 that's what we're doing when you're evaluating  
16 the measures. And so that's why we do want  
17 them to meet the criteria to a significantly  
18 good degree. The stakes are high, we know  
19 that.

20           CO-CHAIR HOMER: Tom?

21           DR. MCINERNY: I'm wearing a  
22 couple of other hats for the AAP. One, you

1 know, we're finishing up our mental health  
2 project for primary care, we have a mental  
3 health taskforce, we're going to publish a  
4 toolkit sometime in probably mid-2010 I hope,  
5 it's closing in on being finalized.

6           And the goal is to try to get  
7 primary care pediatricians to be more  
8 comfortable with, to be more knowledgeable  
9 about identifying and treating mild to  
10 moderate mental health problems in children  
11 because there just aren't enough mental health  
12 specialists to go around and we all know that  
13 a small percentage of kids get mental health  
14 care who need it.

15           And I don't know when we're doing  
16 the call for measures if we could specifically  
17 kind of look for some outcome measures for  
18 how, particularly one of the things we're  
19 looking for is for primary care pediatricians  
20 to collaborate with mental health providers,  
21 and are there some measures that look at that  
22 that lead to better outcomes.

1           I don't know, but that's one thing  
2   that I think is important, and again need to  
3   dovetail that with the mental health group  
4   that NQF has. Because it's, I mean clearly  
5   it's the new morbidity and, you know, we know  
6   that it's close to 20 percent of kids have  
7   some kind of mental health problem and that's  
8   far bigger than most anything else you can  
9   think of.

10           And then the other area that's --

11           CO-CHAIR HOMER: So let me maybe  
12   respond to that because I'm sure I'll forget.  
13   So one thought is to make sure that when we  
14   put out the call that we specify, if we use  
15   something like the acute chronic preventive  
16   frameworks something like that in there is  
17   that we include mental health.

18           So I think we need to explicitly  
19   include mental health in that and flag it. I  
20   personally think that something like -- and  
21   this relates to the care coordination  
22   discussion we had before that collaborating

1 between primary care and mental health is a  
2 beautiful thing, but it's a process and the  
3 outcome is the outcome.

4 So, you know, whether it's the  
5 child mental health status or functional  
6 status or family functioning or something  
7 along those lines would be my inclination.

8 DR. JENKINS: or cost.

9 CO-CHAIR HOMER: Or cost, yes.

10 But we heard that cost was only quasi within  
11 our jurisdiction here. So that was your other  
12 half of your question, I hope I didn't derail  
13 you.

14 DR. MCINERNY: Yes, the other is  
15 the other MH and that is the medical home and  
16 that's clearly not a big resurgent -- big all  
17 of the sudden interest at least and what's  
18 bothersome to me is the pediatrician is at --  
19 almost everything you hear about these days is  
20 with family physicians and internists and  
21 pediatricians who invented the medical home  
22 are being left out left and right.



1           There's not very much going on in  
2 that and actually we're putting together an  
3 EQIP module on the medical -- on helping  
4 pediatricians to, you know, make their  
5 practice into a good medical home. And again,  
6 you know, what measures do we have, outcome  
7 measures that indicate that, you know, if  
8 you've done all this work, how do you know  
9 it's really working?

10           CO-CHAIR HOMER: Again I care a  
11 lot about this topic, I wrote the background  
12 paper for the AHRQ committee on basically the  
13 medical home, it was framed in the legislation  
14 as the most integrated health care setting.

15           But again, that's, I mean the  
16 existing measures of medical home as you know  
17 are largely structural never mind process and  
18 there are some patient experience, reports of  
19 those processes.

20           But I guess I would say what we  
21 would want in this one, again if we were to  
22 even mention it in the call it would be

1 something that would capture the desired  
2 outcomes of a medical home, but they should be  
3 captured by the other things that we're  
4 talking about, I would think satisfaction,  
5 cost --

6 CO-CHAIR WEISS: Care  
7 coordination.

8 CO-CHAIR HOMER: -- care  
9 coordination outcomes. So maybe care -- but  
10 again outcomes.

11 DR. MCINERNY: Apparently  
12 \*\*\*4:14:49.

13 CO-CHAIR HOMER: Yes.

14 DR. WINKLER: However, would it  
15 really be particularly bad to include as some  
16 of the desirable things or desirable outcomes  
17 would be measures of the effectiveness of care  
18 coordination or the medical home, I mean just  
19 to be explicit?

20 CO-CHAIR HOMER: No, I think you  
21 should mention it. I think it's such an  
22 important trend right now and something, yes,

1 I think it's a good thing.

2 DR. DOCHERTY: And speaking along  
3 the lines of our areas or the hats we're  
4 wearing that we want to make sure, and I think  
5 it's covered in this conceptual model, but you  
6 know, when I think about hospitalized children  
7 and I know that that's -- if we're talking  
8 about numbers of affected, this is a lower  
9 amount.

10 But when I think about children  
11 that are left in hospitals today, those are  
12 very sick of the sickest. And more than -- of  
13 children that die, more than 50 percent of  
14 them, unlike adults, die in the hospital.

15 And so palliative care services is  
16 one thing that children's hospitals struggle  
17 with. And so, I was keeping my eye out for it  
18 today, you know, and I think that the way we  
19 measure whether or not children got good  
20 quality of life care/palliative care is sort  
21 of the through the parent satisfaction, long  
22 term, you know, trying to understand, you

1 know, while their child was in the hospital or  
2 died in the hospital did they get the kind of  
3 care that the parent felt.

4 So I just wanted to make sure that  
5 if when we put out the call that we had sort  
6 of tweaked the eyes of those people that can  
7 measure that kind of thing in parent  
8 satisfaction.

9 DR. WINKLER: NQF has actually  
10 endorsed a survey a families about end of life  
11 care. The question is, does it capture kids?  
12 It does, okay. It's just something -- I'm  
13 not sure it ended up on our list. Now that I  
14 think about it I don't remember if I saw it.

15 Yes, and only because I think the  
16 thinking tends to be more at the other end of  
17 life. But if kids are involved, it definitely  
18 should be on the list. We'll need to amend  
19 that.

20 CO-CHAIR HOMER: Again, just  
21 following up on Marina's question to me  
22 earlier about for example the school

1 performance. So, I guess to me that kind of  
2 measure falls into two areas, one are these  
3 broad community health measures, which is what  
4 we want.

5           But there will be people  
6 submitting measures I think on, for example,  
7 asthma. And I would want the people who are  
8 submitting the asthma related measures or  
9 other conditions to think broadly in that  
10 about outcomes that may occur outside the  
11 immediate health care context, which would --  
12 so I think we'd want to pick that up in two  
13 different places.

14           We've done excellent work as a  
15 committee today. I want to thank the staff  
16 for excellent preparation, I think in leading  
17 us to rich discussion. I want to also thank  
18 NQF for selecting a great committee, because  
19 really this was an extraordinarily rich  
20 conversation.

21           And I think I speak for Marina in  
22 saying how much we're looking forward to

1 working with you over the next -- how long is  
2 our duration by the way? Do we have a  
3 timeline?

4 DR. WINKLER: Yes, you do have a  
5 timeline. As I mention, we'll be doing a call  
6 for measures over the winter and you'll meet  
7 again in April to formulate your  
8 recommendations and that will start the rest  
9 of the consensus process.

10 So we'll be friends fairly closely  
11 through at least the first half of 2010 and  
12 the project will end, I believe it's October  
13 in final endorsement. And so we'll keep in  
14 touch with you on that. But so the active  
15 work will be in the next, you know, six to  
16 nine months.

17 CO-CHAIR HOMER: That will be  
18 great. So looking forward to working closely  
19 with all of you. Allan?

20 DR. LIEBERTHAL: Before we finish,  
21 for those of you --

22 DR. WINKLER: Use your microphone.

1 DR. LIEBERTHAL: This actually is  
2 not on the topic that needs to be recorded.  
3 For those of you who came in today may not be  
4 aware the restaurant in the hotel is not open  
5 for dinner. So I wanted to find out if people  
6 wanted to go find a restaurant.

7 DR. WINKLER: And in fact what we  
8 did, because a couple of you asked, is Ashley  
9 has out front a list of restaurants in the  
10 area. This actually in the area around Dupont  
11 Circle there are an awful lot of really  
12 interesting small ethnic restaurants so  
13 there's a lot.

14 But the list is rather extensive,  
15 they've starred a couple they think are grand  
16 and we very much encourage you to explore and  
17 even though it's rainy out there, you're  
18 pretty close to a couple of really nice ones.  
19 So the list is out on the front table that  
20 Ashley has for you.

21 I think we're starting at 9:00  
22 tomorrow morning. There will, I think coffee

1 starts at 8:30, yes. And so our morning, we  
2 may finish more around noon-ish. We'll have  
3 to kind of see, you guys tend to be a bit  
4 efficient.

5 But we've talked about what the  
6 plan is for tomorrow, we're going to talk a  
7 little bit about, you know, how to -- not only  
8 what does the call for measures say, but who  
9 do we send it to.

10 And then we'll talk a little bit  
11 more about the measure evaluation process so  
12 that you'll have an idea of what's to be  
13 expected the next time we actually meet in  
14 person, though I do anticipate we'll have a  
15 conference call or two before that to keep you  
16 up to date on what's going on.

17 And once we have a better handle  
18 on the response to the call for measures, see  
19 how good we were, we'll know what the work  
20 plan is a little bit more detailed.

21 So any questions for anybody?  
22 We're certainly going to be here, we're



1 actually not planning on picking up and  
2 leaving right away, we've got work to do for  
3 you. So if there's any questions or issues,  
4 feel free.

5 DR. BURSTIN: I'll just add that  
6 we also will look towards you to tell us where  
7 there are some good measures. So we don't  
8 often get just what comes in over the transom.  
9 Actually, a good number of those measures and  
10 the larger outcome, the adult outcomes  
11 committee came because of lots of sort of shoe  
12 leather work on the part of the steering  
13 committee and us.

14 So let us know if you know there's  
15 some good pockets of measures out there. For  
16 example, going back to your point earlier,  
17 measure developers who wouldn't otherwise  
18 think to submit to NQF, please let us know.  
19 We're happy to sort of the queue them to get  
20 them in.

21 (Whereupon, the foregoing matter  
22 went off the record at 4:21 p.m.)

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