

NATIONAL QUALITY FORUM

Moderator: Elisa Munthali
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2:30 pm CT

Operator: Welcome everyone to today's conference. Please note that today's call is being recorded.

Please stand by; you're free to begin.

Elisa Muntahli: Thank you, Sarah. Hello my name is Elisa Muntahli; I'm with the National Quality Forum.

I'd like to welcome and thank you for joining us today with very short notice.

Also on the phone and working on the project are my colleagues Helen Burstin and Kristin Chandler. But before I turn over the meeting to the committee's co-chairs, Paul Jarris and Kurt Stange, I wanted to explain why we're meeting today.

This call is a continuation of the steering committee's discussion from the January 26 call in which they provided initial comments on the first draft of the commission paper on population health.

And the first draft of the call for population health measures for say, two of the projects. As you know the paper includes an environmental scan on existing population and community level measures as well as depth analysis, but it also presents framework for measuring and assessing population health, determinates and improvement activities.

In addition to that Matt Stiefel with some continues inputs from the committee has developed an alternative framework for assessing and measuring performance measures within the context of the NQF endorsement process.

This framework really is truly intended to inform the committee's work in developing the upcoming call for measures. And we'll ultimately provide additional guidance.

We're hoping to measure submitters and to the committee as they assess and evaluate population level measures. And so today we're hoping to finalize both the framework and call for measures so that we will be ready to go out for the call in mid to late March.

So with that, that's just a little bit of background that I had. We got started late and we just have an hour and a half. And so I will turn it over to Kurt and Paul to lead us into discussion of the framework.

Paul Jarris: Thank you everyone again for coming on the call. It was short notice and we apologize for that. We'll try to give you a little more notice in the future.

Hopefully, you've been able to read some of the materials prepared and again we want to thank both Dawn Jacobson and Steve Teutsch for the background material and paper that were - were fined since our last discussion.

And also we have in front of us our - the call for measures which today we hope to go over and finalize. So with regard to the -- you can go to the next slide there, I think you were just on -- with regard to the framework I thought it would be helpful given the amount of research that Steve and Dawn put into this for Steve to lead us through a conversation both in the criteria you used to select one of the five models you presented.

As well as to some of the -- and both walk through those models with us. And we have slides there for you. And following that we thought we'd have the opportunity for Matt to walk through the model he's developed.

And then as a committee really have a conversation. And I think there are several things we should be listening for as we go through these models. You know, one is, do any models capture what we're trying to say in the call for measures.

Are there any of the models we're looking at that clearly do not capture it? And then a question of can these models be combined or aggregated in some way that might capture what we are trying to say?

And then finally I think is worth asking and I think, you know, Kurt might want to expound on this question of, you know, given how far we've come in develop in our thoughts, in the call for measures, you know, do we want to consider not putting a model into the call for measures?

Because most commonly the call to measures don't have a model in there. So Kurt let me ask you to make some comments and then we can turn it over to - to Steve and ask if anyone on the committee has comments or questions.

Kurt Stange: Okay, the only comment I would make now is just a framing comment. We were ((inaudible)). Elisa and I were talking just before this call recalling when we initially started talking about the need for models.

And that was when we heard that the call for proposals was going to be pre-narrowly focused on forward health behaviors. I think that as a result largely frankly of the discussion of the models in particularly Matt's model, the actual call for proposal has moved in the broader direction.

And so the question I would ask as we listen to the models is, what effect we want the model to have on the potential model developers? What are we trying to - to say?

I think our initi- if I recall, our initial thinking about this was that we wanted measure developers even if they were doing measures on - that were pre-narrowly configured on one of the determinates of health to have a larger -- to put that development in a larger context of the multiple determinates of health in actually the health of a population.

And so that's one of the things we were trying to convey with the - with the models. Let's just -- as we're going to the models -- let's just think of how what they might say to model developers and - and what we want them to say to - to model developers.

Paul Jarris: Do anyone on the committee want to make any comments or other statements before we turn it over to Steve?

Male: Did you say that there were PowerPoint slides?

Paul Jarris: On the website, yes there should be.

Elisa Muntahli: Yes, they should be -- Kristin?

Kristin Chandler: Yes.

Elisa Muntahli: Hi, is the web working fine or are there any issues?

Kristin Chandler: Yes, it should be all set and then if people -- the slides are also posted to our SharePoint page currently if people need to pull them up that way.

Elisa Muntahli: And just so the committee knows what I did is just pull for the framework the information that's in the paper. So if you have the paper in front of you, you can also reference that.

Paul Jarris: You know, some of the slides are a little bit blurry. So you might want to...

Elisa Muntahli: Yes they are.

Paul Jarris: Yes, Page 13 is where the analytic framework is, so if you want to flip to the printed or SharePoint document that would be a page to go to. Steve did you get your homework assignment via email?

Steve Teutsch: No, I didn't actually. But I can try and walk you through this...

Paul Jarris: Just want to make sure you were on your feet.

Steve Teutsch: You'll find out and unfortunately Dawn is planning to join us but she -- it'll be later in the discussion. So I haven't seen these slides either, but do you want to walk through the next one and I gather you would you like me to walk you through some of these frameworks?

Paul Jarris: Yes, and I think the background that I think you were that was interesting is you said you really looked for frameworks that depicted three elements: total population health, determinates of health and health improvement activities.

And all of that was in a context of measurement. So maybe you can discuss that a little bit more to tell us why out of the universe out there you picked these - these five.

Steve Teutsch: Well, I think there were -- that was certainly an important aspect. The other is as we all know there are lots of different models about how you actually affect change. And we were not trying to describe that.

But we were actually looking for models that not only are understandable and reasonably parsimonious but also models that can be used to drive us towards indicators as opposed to understanding lots of things about the process or programs or implementation or coordination or all those other things that we know are important actually to get this job done.

So we focused our energy primarily on those that we thought linked in some fairly concrete way to - to measures. And maybe the best thing to do is just walk you through the ones I have here and you can stop me.

I assume we have the ones that were on the paper. I'll find out in a minute.

Elisa Muntahli: Yes, it's what you have on the paper. No surprises.

Male: Hey Steve, by indicators you mean the determinates of health as well as the health of a population?

Steve Teutsch: Yes. Yes, I think - I think that's right. I mean we've -- we're going to be talking about different ways to do it. But we're looking at things that actually lead to metrics of things we want to measure.

And those can be determinates, those could be behaviors, clinical services or truly outcomes. And you'll see that they're handled in different ways. And part of a goal here was to begin to show the challenge of integrating the clinical and the more population oriented framework in a - in a common framework in a common model.

Paul Jarris: But this call is for the population measures so a framework that actually had the clinical measures I'm just thinking again to the effect on the measure developer, that might be confusing.

Steve Teutsch: Yes, I mean I - I mean that's the focus here. On the other hand we want to show how the clinical and the medical and the population integrate together.

Male: I think that'll be important because the focus is supposed to be specifically on clinical that if we don't sort of meet people where we are and then stretch them into population, they may not have a context.

Steve Teutsch: Right and you'll see on the last one we actually have a model that tries to flesh it out in - in some detail to show how they actually intersect. Because some of the others are - are a bit more distilled and high level.

So the first one which should be on your screen I expect it's familiar to all of you, that the basically an ecologic model. This is the version that was used by the advisory committee for health promotion and disease prevention in developing the healthy people framework.

And it's a - it's a model that basically starts in the middle of course with the biological and the individual determinates of - of health and then progressively moves out through behavior's family and the various social physical environment -- policy environment.

There are a couple of other things to note about this - this one. One is that it really is meant to offer the pick of a life force so that one thinks about all of those factors from actually conception through - through death.

The figure that's in here of course goes beyond just that ecologic framework and actually does describe a model, you know, talk about interventions and what they - what they're intended to yield which I think are of less interest to - to this group particularly in the sense of...

But it does provide a framework the best. Do you want to stop at each of these? Or do you want me to continue to walk through them and then come back?

Paul Jarris: Anyone on the committee have a comment or question about any of - any of them particularly what you like, what you don't like? If we can quickly make that and then we can move on, in case we want to footnote something.

Steve Teutsch: It's my guess that you'll be more interested in the ones towards the end than this.

Male: And you also refer to the page in the...

Paul Jarris: Right, we're on Page 14 right now on the document.

Steve Teutsch: Okay. Let's -- moving to the next one.

Paul Jarris: And that's Page 15 in the document.

Steve Teutsch: This is a framework which ever could probably describe it better than I can but basically grows out of the center for medical and Medicare Aid Innovations Activities.

And there are -- and this basically is looking at the AAA for better care, better health and twice to link events into the context of community health outcomes.

You can see the key domains for - for better care which are probably less the framework here but deal more with the process of care and - and some measures of that. The - the second part deals with better health, which are the key factors which are more our focus.

And again divides them into the behaviors with healthcare, social economic factors and the physical environment. And then subdivide those into various components.

And we'll be seeing variations on these health factors with slightly different names in some of the other models as well.

Paul Jarris: So good you have that up there.

Steve Teutsch: The -- on the following page -- and I'm trying to crosswalk here, you've got the -- some better health community health outcomes and you can see again on the left see reduction, disease and injury and decrease on unhealthy behaviors should improve life expectancy and well-being.

So the goal -- the thought here is of course that ultimately health is a - is a contributor for overall well-being and that we can - we can focus there. And then there is - then there is the example here that, you know, of - of different measures that we wanted to look at for better care and better health.

Paul Jarris: Any question or comment about this framework? One thing it does -- the second component on the last slide, you know, that'll have better health, key health factors.

There's a couple of things, it does capture health care as in - in a larger context -- within a larger context than it affects health. But it also elicits a number of different factors quite well.

So that's a nice little slide on that one, it doesn't get toward the bigger well-being in final outcomes. But it does capture the health factors pretty well.

Steve Teutsch: Right. It does also not capture the some of the upstream determinates and be- as well as some of the others, at least in terms of utilization.

Paul Jarris: ((inaudible)) and those types, right?

Steve Teutsch: I mean not on the example that they've provided for us here.

Paul Jarris: All right, right. Next comments so we can move on to the next slide? Okay.

Steve Teutsch: The next model is actually one that Dawn's used extensively here in L.A. County which is treatments, models in results accountability. And in general we have a - a set of from the left a set of goals and a set of indicators and then effective strategies by which one wants to achieve them.

That's sort of the population health side of it. As you look towards the right you see the variety of performance - program performance goals and measures that are much more concrete and think that you can measure at the - at the local level. So this basically tries to separate out some of the more operational programmatic measures and goals from the actual population health metrics.

And as you see you're shown on here where of course the different some of the different resources actually fit in like healthy people and determinate space strategies from the community guide.

Then you can want -- the example that - that - that's here is from immunization where the goal is to reduce sober, morbidity and mortality vaccine preventable diseases.

And then we have more specific population metrics that we can actually measure over the shorter term which are the opportunities of children under three who are up-to-date basically complete on their vaccines given current ACIP guidelines.

Then we have a set of evidence best practices and these are just examples of those and most of them come out of the - the community guide on things that can be done on a programmatic level to actually improve vaccine - vaccination levels.

And then we can see also the nature of standard for the performance goals on percent of programs public and nonprofit partners who routinely meet the standards through immunization for a specific measure in this case reminder and recall.

Mike Stoto: This is Mike Stoto. I think there's something really important about this model that - that some of the others doesn't pick up and that's the - the difference between the population health outcome on the - on the left and the program performance on the right.

And I think that in the note I sent around yesterday that's a distinction between the community health needs assessments that the IRS regulations are calling for on the left and the - and the improvement plans on the right and some of the other things. I think it's an important distinction.

Steve Teutsch: Yes, it's much more operationally oriented for both of those on the ground.

Mike Stoto: That's right. It doesn't -- I think in a way it's not an alternative to some of the other models because the other models lay out what are the factors of the different places?

But it's - it reminds us that there are two different jobs to be done by these measures that were prone to be developed.

Paul Jarris: Thank you.

Steve Teutsch: All right.

Paul Jarris: Other comments so we can move on.

Steve Teutsch: All right, so we'll move to the next one which we have in a couple of different variations which are the Evanston Stoddard model which is modified by (Ken Din) and has been actually used extensively in the county health rankings.

And basically it is what we see on the left is a set of - of outcomes that relate to morbidity and mortality and some various aspects of that relate to disparities and a mix of populations of interest.

And this one recognizes of course that on right those things determined in large measure by the - the determinates and health factors and we see a slightly different constellation or framing of them here.

It includes not only the clinical care system and behaviors, social, physical environment but this one really talks about genetics as - as part of the basic biology.

The bottom part of that then shows the policies and programs that are designed to - to influence - influence those things. And the - the next one which I think is in some ways a little bit more - more streamlined is the one that's used by the county health rankings.

And what they've kept the - the distinction between health outcomes and health factors. So that at the top you see they health outcomes divided into morbidity and mortality.

And then the health factors that contribute to those health outcomes. And those are divided into the four categories you see here. The genetics that's been removed but the others are - are basically similar to what we saw in the prior Evanston Stoddard model.

There's some additional elaboration of them here as to what are some of the specific components that go in to each of - each of those - those boxes. The other thing that was done in this model was to actually come up with some relative weights for the relative importance of those different domains.

You can see that basically social and economic factors account for 40% of the weight with the health factors, behavior's 30%, clinical care is 20% and the physical environment 10%.

There's recognition here of the importance of programs and policies is input but there's really no set of metrics that are attached to them. As all of you - you all seen the country health measures to basically have a set of - of scores in each of the categories that roll up into health factors and a separate score for health outcomes anyone can compare them.

Mike Stoto: I think the other thing to note about this is that it's very practical in a sense that they actually went out and got these data for the health factors and the health outcomes for every county in the country.

So it's - it's basically takes the ideas that we've seen on some of these other ones and have reduce them to something that is really very doable.

Paul Jarris: So would they be submitting some of those as the essential measures?

Mike Stoto: You know, it strikes me that we want to encourage that if they don't have that in mind.

Steve Teutsch: Or you can use them even if they don't submit them, right? The -- it had the advantage that they are - they are available essentially everywhere. It has the disadvantage that because they have to be available everywhere.

There were some compromises that were made in the - in the ones that were chosen.

Male: ((inaudible)) in Boston at a meeting with talked to them briefly about it involving the process of ((inaudible))...

Paul Jarris: Speak up just a little bit.

Male: ...measures in their models are originals. They are all -- I mean that's the existing from secondary sources. So the - the -- I think the added value here is the way the measures are abrogated and rolled up into a score.

The other thing is that the obviously the focus is principally on permanents. It's pretty thin in the topic of measures that population health at the top mortality, morbidity, it doesn't draw attention to much morbidity which, you know, arguably is a free essential point in a system of population health centric.

Steve Teutsch: Right. Because it's very action oriented in terms of helping people then figure out where they need to focus. All right, so moving on...

Male: I think it's - I think it's important to remember how this whole NQF practice works at least if I understand it right, is that we're not actually producing measures.

We are asking other people to put forward measures.

Steve Teutsch: Right.

Male: And - and so if - if we -- it's either the - the ((inaudible)) people, the (Kindic) colleagues or all these members these measures actually come from CDC data some place.

If someone wants to sort of put them forward to be endorsed by NQF that will be a useful thing. Because then, you know, when - when hospitals doing their community health needs assessments in the future are looking for NQF endorsed measures that would be an added benefit.

Paul Jarris: It'd be a huge benefit if it's quite actionable by people that these are not some separate things. These are data that they've been using in other forms what would be a -- I think that's the kind of measure we'd want to call for actually.

Helen Burstin: Yes, and this is Helen. We actually have a certain amount of experience with CDC measures from other national surveys. So that would not be out of line for our usual kind of work for endorsements.

Male: We're not looking for innovation in this case; we're looking for existing things.

Helen Burstin: Yes.

Steve Teutsch: Yes. And many of the measures actually come from other sources besides CDC.

Male: Right.

Steve Teutsch: Things like food and education and other kinds of things come from other standard sources.

Helen Burstin: Yes.

Paul Jarris: If you look at the social and economic factors there's the 1, 2, 3, 4, 5 different categories under that, all of which would have published data from some source. Would that aggregation of those five in between measure of social and economic factors be something that would be submitted for endorsement?

Helen Burstin: It certainly could be especially if they've done the work to show that that - that would be essentially be a composite measure that those elements hang together they have a logical meaning together and they need to determine whether they waited.

I mean there's a little bit of work if they actually want to create a single score out of that, but quite doable.

Paul Jarris: And then likewise all of that into a final score?

Helen Burstin: Yes, I get it depends on whether they actually done this work and they've got it tested. So for example, I know (George Eiserman Health Partners) has a R&M composite that looks at some of these elements already, that's tested I think may be submitted.

But again, you know, I don't know with the how far ahead some of these other sources are. I did have a conversation with (Peter Brisk) just to see the level of interest with some of the CDC folks and they would certainly entertain taking a look at some of this and seeing what they have.

Paul Jarris: Okay.

Steve Teutsch: So just -- based on my understanding the folks at the University of Wisconsin who do actually flesh this out did a good job of getting the relative weights among all of those things that are in those dark blue boxes of behaviors and clinical care and support.

I don't think it was quite as systematic in terms of how they got the - the weights associated with those things on the that are in the boxes on the far right.

Male: That's right; it's just a simple unweighted average of normalized scores in each of those. So there wasn't any emphasis to try to weight the process.

Paul Jarris: I just want to note that the discussion on this really seems to have some readiness with both our goals of having submitted some conception ally simple and action go by medical developers and then actually the data of availability being usable for the excellent end user.

Matt Stiefel: And just to comment on that on this particular topic conference that the -- I mean that's right, it's a practical application. And it's focused on determinates it's not pretty dependent upon population measures of population health.

And the biggest criticism to date has been the bluntness of - of the scores at a county level of not being able to check a lower level of measures. But we're going to have that problem, you know, in a lot of districts.

Paul Jarris: Really depends on your perspective because at least, you know, I think the clinical world comes with they measure up - they add measures of individuals up and therefore you can get to a very low level.

But you have a very hard time getting to a high population level. In public and population health we do the opposite. We take the aggregate populations measures and have a problem narrowing it down towards smaller individual or group level.

But I think we just have to accept that and - and rather being blunt, that's actually at the population public health level, having things for every county in the country is - is actually a pretty good resolution.

Male: And for some of them you can actually refine them more it's just that they haven't done that. But large cities that are doing, you know, surveys and things like that actually can break them down further.

Paul Jarris: But it's very expensive it's a matter of oversampling. There just isn't the money to do that.

Matt Stiefel: The current challenge that (Kindic) raised was signal with regards to improvements over time.

Steve Teutsch: Yes, that's the sensitivity of these measures could change.

Paul Jarris: Right, because the data could be quite old by the time you - you smooth it.

Steve Teutsch: Right. And in fact some of these are rolling averages - aggregates over several years for small counties.

Male: And many of them are five year averages.

Paul Jarris: Yes, yes. Well, I think we just have to keep in mind the differences between how the clinical world develops measures and how the public health world does and I think we're trying to - to somehow bring them together.

But we won't be able to do that until we have really robust national health information exchange systems.

Kurt Stange: And let's not make the perfect the enemy of the good either. I mean it's hard to imagine alternatives that are much better than what we have here or what these measures are intended to do.

Paul Jarris: So, I think why don't we go on to the -- if we're ready to?

Steve Teutsch: Okay. So yes, I think where you are on this is this is very much where - where Dawn and I were actually that the county ranking models are probably the one of the preferred ways to go.

But the last set here to actually come out of the IOM report on measurement from I guess early last year and they're two parts of it. The first part that's shown here is an - an attempt to basically show across the - the middle of this graphic how one moves from a needs assessment through priority settings then to identification resources capacities.

Then a set of processes interlinked immediate outcomes and health outcomes. The purpose of this was basically to begin to understand the entire process and understand the - the need to link these up to be able to understand the impact of programs.

You can see though that all of this is intended to link upward to the not only health outcomes but that it's also occurring in the context of social environment determinates of health which these interventions are actually supposed to be trying to change as well.

The lower box I guess again tries to represent the fact that they - this is all about geography and individual stakeholders understanding the distributions and population groups.

Then the next one probably can't read it at all for those of you who have the document in front of you. But if would be easier, it's on Page 19. So the - the IOM committee realizing that it was sometimes hard to wrap ones head around on the - this in the abstract developed a couple of models of how it would or examples of how it would play out in social specific conditions and realizing that we were talking in many cases to a clinical audience. We took a one that was on cardiovascular disease and another that was on infant mortality. And you see the cardiovascular one here.

And -- but what I try to point out was that they on the left you'll see a clinical approach. And you could then look at the not only the interventions there but you can talk about the domains of -- access of that care and the quality of that care.

And the set of measures that go - go under that in terms of the resources that are available but also the kind of test procedures other kinds of measures that would relate to cardiovascular care for different organizations that are at the bottom, different stakeholders.

On the right you see the multiple determinates approach which many of us might call a - more public health approach which not only looks at behaviors, clinical care but education, nutrition and the other determinates as well.

And then tries to flesh out some of the measures and stakeholders that are involved with each of them. We did this for infant mortality as well and what ones see is that while things on the left in the clinical side of course relate very specifically to some disease specific measures.

The things on the right in general lead to some more general ones that are actually the same regardless of whether it was talking about infant mortality or on cardiovascular disease.

And in fact that there's a large level of commonality and hence our interest in focusing on many of those - of those characteristics as having more diffuse and positive effects.

So that's the IOM model which again the cardiovascular is more of just an example. And if there are any comments or questions about that.

Paul Jarris: You know, it's a very nice example more than model. You get people to look broadly at both determinates and clinical and how the two can be married together. Any other comments, questions?

Okay, I think the next one we have is Matt. We had yours as understanding this based at least in part on the Evanston Stoddard model. We thought it would be before going into to others we'll give you a chance to speak about it. Maybe you can tell us a little bit about this model and how you developed it.

Matt Stiefel: Sure. Well, as you can see from the conversation we just had, you know, the first question - logic question that you'd ask is, "Why bother creating another model, there are plenty of them out there?"

So the reason that I had for creating it was to I think get some clarity in the potential framework of the causal pathways between determinates and outcomes.

For example, in the County health rankings model it just kind of shows that a bunch of determinates and some outcomes that are connected. And I think it's important and to - to think of

the cardiovascular, obviously you can get much, much more complex than this if there's any kind of model and supplication.

But I was also thinking about a model to guide measurement and to be able to explain in a way between upstream to downstream framework to see where its measurement fits in.

A lot of measurement has focused on behavior factors and disease injuries well, physiologic factors, BMI and blood pressure and cholesterol. And you can see pretty visibly in a framework like this that there is - there are important further downstream measures of health and punctual status maintained that - that follow along with a causal pathway.

The other reason was to as you saw with a lot of the other models there's a lot of focus on understandably on improvement activities. And I think that's one of the top experts of today's call.

Is the extent to which this call for measure includes improvement activities And, you know, Mike made a case for that but so a question that's why you stop with that.

But the other is a significant focus on one of the models on determinates in not much focus on measures on health -- measures of population of health. And so part of the reason for doing this was to get a little bit of guidance to think about what we mean when we talk about measures of health.

And to - and to tease that out a little bit from looking at the physiologic factors such as, such as BMI to measures of disease and injury and measures of health and death and well-being. And they're all - they're all different and related in a causal pathway.

But important to distinguish as I - I think I wrote in one of my comments that people with the same physiologic patterns of behavioral factors may have very different manifestations of disease and injury and like similarly people with the same level of disease.

They have very different importantly different functional status of self-contribute in different trajectories toward death which are important to measure.

And those I think is just important to note that those do still fall short of true measures of qualities as life and well-being. It may well fall outside our frame here.

But important to note that - that health is one set of contributors to well-being and other factors of quality of relationships, quality of work life and other important factors of people's lives contribute to well-being.

And then the other - the other point of doing this is to begin to show some of the importance reclusiveness in my own. If you can, you can get deeper and deeper there but just to show the therapy.

And finally, submitted two things. One is it's because this frame is as let's see elaborated in the - in the document is from the - the two points of view of the public health system and the clinical care delivery system.

The green box is an attempt to show sort of the important connections that those have in influencing these causal pathway. And then the last point is in from of the committee and every one of our sessions about the importance - importance of looking at equity and the distribution of health.

And if this is just an attempt to show where measures of equity are important to acknowledge and take into account in a framework like this. So regardless of the model selected I think one and it should shed some light on measurement because that's the topic.

And shed light on the causal pathways and especially if we're looking at measuring the most and more upstream factors. We should be able to and perhaps require measured submitters to articulate the causal pathway.

And then finally, to give a little bit more guidance and clarity about what we mean by population health. It's kind of the essence of this work in distinguishing, you know, among physiology disease, health functional status and well-being.

Elisa Muntahli: Hello.

Paul Jarris: We have good talent. I guess everybody's pensive.

Matt Stiefel: I didn't mean for that to be such a conversation.

Operator: And this is the operator. Did you want lines open for questions at this point or did you want to continue and keep them at the end?

Elisa Muntahli: We can keep them until the end.

Operator: Thank you.

Kurt Stange: Well, I'll just start the general discussion, this is Kurt. I found just - just walking through them like this somehow a lot more helpful than reading through them a number of times. So thank you Steve and Matt.

Matt, I think your model has been incredibly helpful in our - in our process. I mean I think it was a pivotal moment in our - our first meeting when you proposed it and helped us even as you were talking narrowly to put things into a larger context.

And so I think your model has always been in tune to everything we've done and that's -- I like a lot of aspects of it. And I like some of the other aspects of actually all of these.

And I think both the (Adlin) model and the (Freedman) model really speaks to some of the process kind of operationally about how we might want end users using some of these - some of these measures that are being called as well as your model Matt there.

As far as what we're trying to do with this call but I really felt the most resident in our discussion with evidence in the Stoddard model was actually both versions of that was both giving people the simple idea that we want to measure the health of a population and then the determinates of the health.

And then I think the fact that it links to existing measures that people who are already familiar with in which there's already been a lot of work done developing reports at a geographic level, at the county level and state level I think it helps people to think about - how they - what a population might be and how you might - might actually use these - these measures.

So as far as something that the call helps to get our - gets people's heads around it and maybe actually help people to think that might not be used to thinking about doing a - a measure for NQF might think - they might think, "Oh well, this does apply to me. I use these things all things all the time but what I'd like to do is modify them this way or that way."

I think what Matt's particularly pointed out to us and others have as we were talking about that model is we use that I think we need to in the words around that talk about expanding what they - what they're models says about health. Because it is mostly about determinates.

And really it's right now about morbidity and mortality. And I think that, you know, talking about quality of life and function and others I think we have to expand a little bit - a little bit on that. But I think that would be very - very doable using that as a framework. Matt I'm a bigger buzz kill than you are.

Helen Burstin: This is Helen. I guess the question for the chairs and the folks on the call is what if, you know, what if anything do you think we should try to incorporate to provide greater guidance for our measure developers essentially submitting measures to us?

Mike Stoto: Can I make a suggestion? This is Mike, maybe for the call for measures which is has to be relatively short and simple. I think that the - the evidence in Stoddard's model either one of the ones on Page 18 of the background paper would be good.

And actually incorporated right into the call, rather than as kind of an addendum currently stand. But make the reference to - to Matt's model and the more articulated version of it. Matt I presume at some point you'll publish it so that would be possible.

Because I think that's the ideal that the feedback loops and all that is important but maybe too much more than we need for the call per se.

Matt Stiefel: So -- this is Matt -- so one thing I wish that the county health ranking model get a better job of providing guidance for that is in the measurement of health. It just so - it's doesn't - it's thin there and, you know, on the bottom part it says morbidity/quality of life.

It doesn't provide a great deal of guidance and at the top it just says health and quality of life. And they measure self as a single measure in their model. And it's just in a call for measures population - call population itself is that seems like we'd want to provide some - a little bit more elaboration somehow about, you know, if one extreme of measures is physiology.

And the other extreme of measures of quality of life and between our functional status is disease death injury and self-perceived health and that it's - that's the one concern might have with the county health centers.

Mike Stoto: You know, this is Mike again. I'm going to change my mind and say that I really think Matt's model should be the one that we include for that reason that he just said and also because it lays out the idea that it kind of a logic model of thinking, you know, if you change this that will have some impact through this change to what we care about in the end.

And I think that the evidence in Stoddard one at least the one on Page 18 of the background paper just had the arrows going back and forth without me saying, you know, or even hinting what the connections might be between the different components.

And I think that in when we make the call we should ask is I think Matt suggested that people arguing for a certain kind of measure should have to make a case to where it falls in this logic model.

Paul Jarris: I wonder if Matt's concern could be dealt with in a way that actually emphasizes actual measures, multiple measures of health as opposed to determinates by actually having asterisk in a box that really calls out that we think that that's a weakness in that - that model in the way the population health is currently measured.

That we would call for greater granularity there and actually just waive the difference in multiple ways of assessing the health of a - of old people in the whole population.

Matt Stiefel: That's a possibility. I do think it helps because we do know not everything about -- we do know something about this upstream/downstream causal pathway between physiology and quality of life. It's probably worth pointing that out that it's not just a heap of measures of population health but there is some order to it.

Kurt Stange: Tell us - tell us Matt how you think a measure developer would use that that's really important insight about the - the causal pathways and the interacting route. How would that translate into measures?

Mike Stoto: Well, here's an example, this is Mike again. I mean, you know, in the prevention - preventive services measures we've been looking at in the other part of the project and most of the other NQF things. People have to say whether it's something for structure a process or an outcome measure.

And if it's a structure or process how does that contribute, what's the evidence that that contributes to the outcome that's desired? And in a way that much more complicated when you're talking about population health kinds of goals and interventions. Because it just goes to reality more complicated and this would be kind of elaboration on that idea.

(Sarah): You know, this is (Sarah) and Kurt I might be able to answer that question. But Matt please feel free to correct me, but as a recovering measure developer really how - how I would have done that, you know, working with an advisory panel is, you know, what a measure developer needs to do is first of all identify where there are weaknesses in measure sets.

And so, you know, you do want some sort of framework, you know, and typically we did it by condition. And looking at, you know, processes of care or processes of disease or, you know, the epidemiological factors of a disease.

And then looking at, okay so where are their clinical guidelines or evidence based practices or best practices or something that could then contribute to one of those areas where there was a (dirt) of something?

So in this case, you know, I would have done a kind of systematic review of clinical guidelines and literature and said, "Okay, you know, in looking at population health overall where are our biggest issues and where are there opportunities to impact those issues and you know, figure out where they would fall under each of those areas?"

What I really like is Matt's comments that he put in the rev- you know, into the revision of the call for measures. Because I think what he did was nicely aligned. Some of the language in the call for measure language and so it aligns with the framework.

You know, I think there could be potential to add some more examples if we needed to. But I think because there is alignment in some of the language that Matt suggested in the framework, there's enough information in there now that as a measure developer I understand what we're looking for.

Kurt Stange: I guess my question was about how -- I'm trying to think of how a measure developer would use the recursive aspects of the model and if that's - that added complexity is - is worth it.

I'm clearly thinking about what to do about - about these different measures and trying to get intervention you have to think in a systems kind of way. But how that affects actual measures is less clear to me.

Matt Stiefel: You know I think there is a challenge for measured developers if coming from modelers I think it's critically important. You're right, I think the recursive is a difficult to put together. But the left to right arrows I think are - are pretty important especially with this very broad framework that we have developed.

I think its great determinates and outcomes and upstream determinates like social economic factors. But, you know, if there's a measure of people living in neighborhoods without parks or access to fresh fruits and vegetables or living next to a freeway with environmental solutions ((inaudible)), I think it's because - it's pretty open field here about the frame that we've linked.

So I think it is incumbent on measure proposers to say, "It's a - it's actually pretty upstream factors, here's the evidence that the - of how these factors contribute to our measures of population health."

Those aren't -- they're fundamental distinction is the distinction between determinates and ((inaudible)) clear and, you know, that's probably the boundary is probably right around physiology.

And then I think it's just the description of the evidence that obviously the further right you go the shorter the pathway is than if you're measuring functional status or self-health status the, it's not much of a challenge - the causal pathway isn't a challenge because that is the outcome of population health.

Paul Jarris: This is Paul, can you hear me?

Matt Stiefel: Yes.

Paul Jarris: Okay, sorry I was muted on the other line. I'm just curious and I'm sorry ((inaudible)) if I missed the segment of but the I was wondering do we need to have a model in there? Can we - we have this background paper published or background paper developed.

Can we just in our call for measures reference this background paper and reference the different models in it and perhaps put Steve's model in there. And basically make the points of here are examples of models that could be looked at to further illustrate what we're looking for.

Understanding that there are strengths, limitations of each of these models because I'd have to say I'm still not comfortable with any one model. And so by laying them out will then the measure developers can go through the same thinking process that we're going through right now.

Helen Burstin: Yes, Paul, this is Helen I agree with you. I don't know that we necessarily need to include a model in there. But I do think it would be helpful and we can certainly reference the commission paper and the variety of models in there.

I think the one thing you want to be able to do and it could just be, you know, a set of bullets or a paragraph, is at least put some of this in context. So that you're actually getting what you want.

You know, taking the best from these various models. We can reference whatever you want. We are often have frameworks in call for measures. I just think this was such a new area the question was would it be useful to developers to have a sense of how would their proposing fit in the broader scheme?

Paul Jarris: Well, there's - there's some wisdom to that, we've been - we've been hedging around this for quite a while and so thing to communicate to us might not be the same thing that communicates to people that are reading this call forward and haven't had the discussion.

So I really think the simplicity is going to be really important for the call so people can have some sort of general idea of what we're talking about before we get down into specifics.

So whether that's a very simplified picture of whether that's a sort of bullet point but having something simple that then references something that's more detailed would I think might be an important way to think about it, to have a start with that.

Mike Stoto: Maybe if we can actually do some user testing, you know, the direct that we put out this week or next week we'll be an opportunity to see how people react to this.

So if we put something in there we could ask whether they thought that it was helpful to have that.

Paul Jarris: You know, I think Mike that's actually - that came up earlier in our pre-call. If we feel the survey will typically have our focus groups develop the questions, modify the questions on an expert panel.

But then we'll go out to, you know, five or six representative groups sometimes more who the survey's intended to go to and have them look at it to say, "Is this clear, what does this mean, what does this not mean?" And sometimes they'll come back and say, "What were you thinking when you wrote this question?"

Helen Burstin: Right.

Paul Jarris: So I'm wondering if we should do the same thing here where if we can build in a little extra time to go to perhaps, you know, some of the groups that are doing NA or BRFS or go to (Kindic) in Wisconsin or even California Health Interview Survey or the New York in AIMS.

You know, some- whatever those groups are and say, "Does this make sense to you and your context and do you have any modifications?"

(Sarah): And you know and perhaps that's one incentive for us to kind of try to wrap up the call for measures. We'd be delighted to help do that, tell us to do the ((inaudible)).

We actually frequently do that, so we'll show the call of people in that area and say, "Does this make sense? Does this have enough information for you?" So again, sounds like a good plan to me.

Male: You know, we've been talking about this for so long we're no longer a good judge of whether it's useful.

Paul Jarris: I think that's probably true because we - I mean we have talked going on a couple hours or more about the different models.

Helen Burstin: Yes.

Paul Jarris: And that's a benefit of all of our collective thinking on them. So I would get back to the point. I honestly don't think there is any single model that does this for us.

And I'm happy to go in with any of those and express my opinion on this and participate in that part of the call. But so referencing a collection of models to say these are examples of types of models.

And then maybe having some bullet points to say here are the strengths in the models we see and here are the weaknesses in the models we see.

Helen Burstin: Yes, or - or one other possibility Paul not even as much as the strength and weaknesses but kind of taking the best of breed. So from all these different models what are the key points about population health measurements that you want to transmit to the developers being model agnostic.

Paul Jarris: Yes.

Helen Burstin: And if you guys want to come up with what those bullets are Elisa and I would be happy to draft that paragraph and get it put into the draft call and circulate it to all of you as we go through that today.

Paul Jarris: What are folk's reaction to that?

Elisa Muntahli: I think it's a great idea.

Matt Stiefel: It's Matt. I think that could work. What I would - I think what I would call out in a description would be in as in the background paper to distinguish among determinates, outcomes and improvement activities.

And I think we need to get back to improvement activities to know what the scope of that is and how it fits. But those broad categories to say something about review -- look at the selection model to better understand our causal pathways among these things that are importance and these can please articulate that in - in your proposal.

And I think it would be useful to give some background on - on the measures of the - the types of measures of ((inaudible)) but that's both the key elements.

Helen Burstin: Okay. You guys want to try to send some bullets along on what you think is the best of all those different models. We'll try to -- after our brief discussion of these last couple of slides try to do it on a draft and get it out to everybody.

(Crosstalk)

Matt Stiefel: I have one more idea to that is the idea that population health we need to look at in equities and disparities not just the averages. I think that's kind of what you're missing from the first paragraph.

Paul Jarris: Yes, absolutely. I think that's true about both. You know, I think the ideal measure would have both - both the World Health Organization's concept of fairness and goodness - goodness and fairness where the ideal measure is to say, "Here's the average and then have a component to say, you know, here's some measure of health in equity or health equity, the difference between the least and most effective populations."

Male: One thing that might help is to move people away from justify the framework to the indicator sense that are already out there and to draw on those.

Helen Burstin: Yes.

Kurt Stange: So Helen I really like those. You said use bullets to use see what the determinates to help outcomes improvement activity into equity and then some examples just to include these in those domains.

I think that would be a really clear way of getting the big idea across the people.

Helen Burstin: Okay. And we can certainly reference the paper so that lays it out so nicely. Should we walk through the last ones about the cost measures?

Paul Jarris: I just want to make sure is everyone comfortable with that. Is there anyone not speaking up who would like to speak up before we move on? Okay.

Helen Burstin: And we'll send it out anyway for comments. So if somebody's uncomfortable even if there's not on the call today, they'll have that chance.

Paul Jarris: Right and then we'll have some comments later if we have time for that also, yes.

Helen Burstin: Okay. So are you ready to move on? You're good?

Paul Jarris: Please.

Helen Burstin: Okay. So briefly we're going to talk about the call for measures. And I thought it might be helpful since Paul and Kurt were on the C-Sat call with us just to briefly give us a quick recap of that discussion.

I think it was a great discussion. They really by the way Steve really found your paper even in the earlier draft incredibly valuable actually to help that context. So thank you for that.

And I think the overall assessment was while there was still some concerns about understanding locust of accountability overall I think there was a great deal of agreement that we should move forward.

And in fact to the point where we've decided that we will go ahead and have a conversation with the Board of Directors on it next month. But we're not going to hold up the call for measures. We

just thought it's more informational for them but I think with the fact that the C-Sat was so generally on board we were not quite as concerned.

So I think we've got to green light to go which is positives and thank you to Paul and Kurt for that discussion. So what you have on the next couple of slides is really I think there's a block and copy from the draft call for measures.

Just putting them up there if there's any specific concepts in here or kind of words missing you think is important for us to put in here, we can do that. But, you know, briefly what we'll try to do as Paul had pointed out early on is tie it back to the NPP and the community approach specifically focusing on community and population and level measures.

We specifically set it up for community health and multi stakeholder accountability, haven't quite defined that but some of that is in the paper I think.

And then list the set of bullets of what would potentially be under there. Is that more ((inaudible))?

Elisa Muntahli: That's just some of it, not all of it, yes.

Helen Burstin: Okay. So there's more in the actual draft call for measures that you have.

Elisa Muntahli: And I think Kristin if you could pull up the call for measures, that'll be great.

Helen Burstin: Yes.

Kristin Chandler: Yes.

Elisa Muntahli: Thank you, Kristin.

Helen Burstin: So we tried to as best we could is list out some of the bullets of what we think based on the discussions we had to date are the things we really want to include and we really focused in on it has specifically including determinates and outcomes as being to the higher priorities.

And I agree with Matt I still like us to return to this question of whether improvement activities are in or out? I think they're a little more complex as performance measures but happy to talk that through.

And then list it out under it some specific items with some edits from some of the folks who made some comments. And we would very much expect and perhaps we can emphasize this a bit more that the call for measures will explicitly incorporate more around equity.

We just had our steering committee meeting on disparities and reviewed all the measures there are in fact all healthcare focus. Some really great ones are on health whether it's seeing other issues but again, very much in the context of healthcare.

So we think we can add that adding additional work you'd like us to try to get people to focus in on. And, you know, we did specifically continue to include some of those key physiologic and behavioral determinates as well as some of the key outcomes.

I think with that I'll just stop and see if you guys have any comments.

Operator: Would you like to take comments from the phone line as well?

Helen Burstin: We'll start with the committee first (Sara).

Operator: Thank you.

Paul Jarris: Do we have to -- should we address this with improvement also?

Helen Burstin: Yes, I think that's the question I think, you know, Matt raised. I think is a - is a good one.

Paul Jarris: I think we have seen such as the community creative services that actually do list out policies and programs and different things that are evidence based, well researched, embedded similar to how the community the clinical guide is embedded.

And those are for example measures of different policies and programs and they implementation such a policy and program is not an outcome but it is an improvement activity.

So I would hate to lose that for example, if a state did not have a -- or a city or county or jurisdiction did not have a clean indoor air policy and they pass that, that's an improvement activity.

I think it could be contained as potentially the surrogate outcome or a proximal outcome of proximal outcome but it certainly isn't an ultimate outcome. So let me just stop there to say I know I think driving improvements especially for things as such long time lags as we have in population health could be very important.

Mike Stoto: Yes, I'd like to support that too. And this is Mike again. And, you know, as you saw I feel strongly about this. But I've been trying to think through how the measures that come out of this process will be used.

And because of some other work I've been doing I've been quite tuned to the - the changes in the IRS regulations that call for both community health needs assessments and performance plans for all the non-profit hospitals.

And you see the same kind of things in the fabs standards and in the maps process and - and so on. But I think that the, you know, the hospitals that's suddenly have to do these two kinds of activities are the ones that are used to going to NQF for guidance.

Helen Burstin: Yes.

Mike Stoto: And I think that, you know, to the extent that we can help - if we can help them with both parts of what they have to do, both the needs assessments and the performance in the plans and measures associated with the plans, I think that would be very useful.

And so, the fact that we have recommendations from the community guide about what works is useful. We have, you know, recommendations from the for instance from the taskforce and others about what to do about preventive services.

But just having the recommendations isn't - is only the first step we have to translate them into measures - performance measures and we do that in our time.

So I think that we can translate the community guide recommendation with the performance to measures for the - the second part of that process and that would be the useful thing to do.

Paul Jarris: Other comments, questions?

Male: So you measure improvement by looking at some of the - the measures and how they track over time. This is almost really some of the determinates of the determinates of health.

So it does expand the scope of this but - but also really is more immediately action, might be immediately actionable by some of the stakes we want to engage.

Kurt Stange: That's right because if you wait until you see the outcomes, you'll just be waiting too long to see.

Paul Jarris: To look at A1C's for diabetes.

Helen Burstin: I'd be curious to hear Matt's perspective.

Matt Stiefel: Well, I certainly understand the motivation to include improvement activities and why bother with this stuff if we're not trying to improve population health.

The question I have in Mike comments to these earlier were very helpful. The question is so where do you draw the boundaries? And in the background paper was - was now that you're thinking about that boundary's is not so clear and especially in the broad frame of improvement activities or health improvement activities.

Hip replacements are health improvement activities, cardiac stents are health improvement activities, I think we could all agree those are all how where does it - what is the frame that we're calling for?

And I think, you know, perhaps it at least ought to be labeled population health, population health improvement activity even then I think you might run the risk of business of population care management or the kind of one to many care managements type activities.

And I think that's not in this frame either so I don't object to the improvement activities conceptually. But I do think we ought to attempt to - to frame it and to draw our boundaries so that it doesn't include population care management or to the extreme hip replacement.

Paul Jarris: I don't think referring to it or using population health improvement activities. I think would probably be helpful.

Male: Sometimes people say population based activities for instance.

Mike Stoto: Again, if you think about the use I mean we're now talking about in the example I mentioned, you know, getting hospitals to go out and start working with health departments and others included in their community to do things more than they currently do.

So I'm not worried about them going out and doing hip replacements, what I want to encourage them to do is to, you know, work on improving the availability of parks and stuff like that.

Male: Or educational opportunities and things like that, yes.

Helen Burstin: I think evaluation criteria could help because again they would need to be evidenced based. I think that gets, you know, Matt's point about in some ways the rationale of the connection to how those actually was resulted improved care in improved outcome, sorry.

Paul Jarris: Yes, with regard to that I think we have to somewhat careful because we can't set the bar so high that no one can ever achieve it. I'm going to use the example of fast food density in a community where in an interstate community where you will clearly be able to show disparities in terms of weight and specific low income community's weight, obesity, diabetes and things like that.

And so to acquire some one to clearly demonstrates that its ordinance regulating or affecting fast food restaurants or fast food density affects mortality would be something that would take so many years we could never achieve a measure of improvement effort.

Helen Burstin: But Paul I think that's very analogous to other intermediate outcomes. I think, you know, saying it affects BMI would be sufficient, there's no expectation for example that we would require that, you know, A1C testing and A1C controls results in a measure that shows a reduction in blindness.

But the evidence would suggest that's the case, so I think there's, you know, I think the evidence could be helpful here. But I don't think the -- I think the intermediate outcomes are probably will be sufficient.

Matt Stiefel: This - this - this is Matt. This example is perfect to provoke my uneasiness.

Helen Burstin: Okay.

Matt Stiefel: Fast foods density is a determinate, it's clearly sort of fits, clearly in this framework as a determinate. So there's no issue with that, but we're talking about improvement activity. So the improvement activity would be to get together a collaborative to work on - on reducing fast food density or adding groc-- that's the project for an investment.

Fast food density is fine as a measure itself but what's the measure of the improvement for it that you'd want to include in this call for measures?

Kurt Stange: So I would have said that the activity is in the coalition again as you said but the - the measure of their performance would be actually fast food restaurants density.

Matt Stiefel: Which is - which is -- I would call a determinate as opposed to an improvement activity.

Kurt Stange: That's right but it measures the performance of that - of that activity.

Matt Stiefel: And that's what we're - that's what we're after is measures of performance.

Helen Burstin: Right.

Male: Maybe just a question on how things are labeled and maybe some examples would make that clear including this example.

Helen Burstin: You know, it seems like a potential, you know, a measure that fast food density would be very appropriate and a measure of a community based or population based BMI would be very appropriate.

I guess the question I hear and sort of Matt's question is, you know, what's the intervention measure in between? Or are those too sufficient?

Male: It's so fast food density and an improvement activity would be to create a coalition to work on that fast food density which could include both policies to affect the density of those fast food restaurants.

And also policies to bring in fresh fruits and vegetables and things like that. So couldn't you just measure there the outputs there would be, you know, on the one end a decrease in density of fast foods and the other hand an output could be an increase in assess of affordable fresh fruits and vegetables?

Those are improved activities with measurable outcomes.

Helen Burstin: Right, I'm just not sure if you think about is the accountability measure. The measure in the middle that you just described about a coalition coming together to do those things is a measure that you would use to assess accountability of some entity.

To me that's just -- you could take those measures and you could repeat them over time and look for delta, look for improvement. But I think what and correct me if I'm wrong Matt I guess the question is, is the actual improvement effort the measure or is it really the intervention to drive the outcomes and the determinates?

Matt Stiefel: That's the question, now taking a little bit to the other side I can see...So here's another example, measuring in a community to the extent to which that community has adopted health impact statements as part of - as part of government public policy, you might call that an improvement activity and is that something that you could measure whether or not a community is in play health impact statements for major public investors.

Male: Right. There's always a kind of continue in these things. I think that maybe some examples in the document can be helpful. The other thing is that if there is evidence say as we view by this community guide that suggest that doing these impact statements make a difference, then it would be more acceptable to measure whether or not you're actually doing what's recommended in the guide.

But maybe always better to have measures about the success of those activities in terms of what the density actually is.

Paul Jarris: Could I -- I hate to be the timekeeper -- but I think we have five minutes and we have not yet open the phones for comments. I'm wondering Helen and Elisa how you want to make that transition now.

Elisa Muntahli: We can do it right now and so I'll ask Sarah, the operator, if you can please open up the lines for anyone who wants to make a comment.

Paul Jarris: Actually, I think this prior conversation was very helpful in terms of there's lots to think about here. So maybe we can all keep thinking about it and exchange some email comments on it. But we do need to get to the public and others.

Operator: Thank you; to the public, if you have a question or comment today, please press star then 1 on the touch-tone phone. For those of you joining us today using a speakerphone, please make sure your mute button is turned off to allow your signal to reach our equipment. Once again, to the phone audience, please press star then 1 if you have a question. We'll pause for just a moment. And once again to the audience, it is star then 1 if you have a question or a comment.

We'll go to Paula Yoon. Paula your line is open, please go ahead.

Paula Yoon: Thank you; this is Paula Yoon from CDC. I'm in the epidemiology and analysis program office. The one comment I wanted to make is and you've talked about this today is really the importance of the context.

If I look at the description of the call for measures at this point and time and think about all of the activities across the agency that I'm aware of, where indicators are being developed to track programs, to measure population health, there are thousands and thousands of indicators right now that are being developed and promoted just within CDC around population health.

And they all have important context around them and so the example that somebody discussed earlier of recommending some indicators that for example non-profit hospitals could use for their community health assessments, that's a nice way to kind of package the - the intention of how the indicators would be used.

The same with the county health rankings, the match indicator, the reason those indicators work is because of how they've been the configuration of what's been brought together.

Just to get lists and lists and lists of indicators I'm just not sure how useful that's going to be.

Male: I think that's a really helpful comment. Do you have -- so are you suggesting that we ask the measure developers and submitters to say something about the context to which the measure was developed and then in the context in which it might be most helpfully deployed?

Paula Yoon: I mean I think that's one way you could do it. The other way that I was thinking, somebody mentioned earlier perhaps a pilot. I'm wondering if you could with your first call for measures really narrow the focus to perhaps community health assessments done by hospitals or to communities that are using community guided inventions.

If you could narrow the focus of what you're trying to use the indicators for, that might be give you a really good feel for the extent of indicators that are submitted to you.

You know, how long they are. I just feel like it right now is so broad. I mean I'm just envisioning thousands based on just what I know people at CDC are working on.

I mean everything that's in the data warehouse, the indicator warehouse at NCHS the reason they're in there is because people submitted them because their useful for what they're trying to do in population health.

Paul Jarris: Okay, well thank you, that's something helpful to think about.

Paula Yoon: Yes.

Paul Jarris: Operator, do we have other questions on the line?

Operator: We do have another question. Peggy, your line is open, please go ahead.

Peggy Honore: Hi, this is Peggy. I wanted to get since we only have like one minute or we're totally out of time what is the comment period, the written comment period for the written report?

Elisa Muntahli: Oh, Peggy, are you talking about the white paper?

Peggy Honore: Yes.

Elisa Muntahli: Okay, it'll be a 15-day comment period we're hoping to post the report on the 9th of March. So on Friday for 15 days and so we'll close the comment period on the 23rd of March.

And we're in the process now of starting to pull the committee to see what day a week after that we can meet to discuss comments and responses on the paper.

Peggy Honore: Okay.

Paul Jarris: That's helpful and perhaps we could use those 15 days or so also to get a couple of different measured developers feedback on the call for measures.

Peggy Honore: Yes. Well, I'm going to make my comments via the web because we're simply out of time now. But they basically relate to the various models specifically the weights on the healthy on the county health rankings.

I'm sort of in support of the model Steve model and then also some - some comments that need correction in the white paper regarding the - the HHS quality aim as governmental public health systems quality aims which are totally inaccurate.

And then also a suggestion towards the back of the document about additional opportunities for alignment regarding the six IOM's domains and the nine HHS domains for public health quality as an additional activity when this was clearly stated in the HHS proposal as an activity of this project, not as an additional activity.

Paul Jarris: Okay. Thank you, Peggy. Helpful comments as well, as we look forward to your written comments coming in. Operator do we have anymore we are out of time, but any more people on the line?

Operator: Actually it appears we've taking all the questions that I queued up.

Paul Jarris: Okay, thanks. Well, thank you to the committee for this as well as simulating conversation and lots more to think about as we can process this brief period of time that we're speaking.

So the staff, a couple of things. We have some follow-up items where we're going to send to Elisa and the committee members bullets on the different models.

And we will also be sending out the call for measures and still give successions about who we might send the call for measures for a small group will come up for reaction, to see if we can modify that.

We'll also have the - the paper I guess 14 or 15 days out for comment and then Elisa and Helen tell the next steps.

Elisa Muntahli: Okay, thank you. So those are the next steps related to the call for measures. And we're just encouraging everyone to any ideas like Paul said just feel free to forward those to me by email.

And I just wanted to tell you about the commission paper. We did talk about it briefly but we'll be posting that again. We're posting that on Friday, March 9 for a 15-day comment period and I wanted to just alert you to the fact that we have built a second web page for this phase of the project.

This is the phase that is solely focused on population level measures and so when it is posted I will make sure that I have URL for the email so that you can get to the page perfectly.

And we'll also post it on SharePoint as well. It's actually on SharePoint right now. So you can access it that way. So are there any other questions, some administrative questions, questions about the timeline?

Well, we just wanted to thank you again. We know it was very, very short notice and we just appreciate your contribution to the project and to the discussion and we'll be in touch very soon.

Helen Burstin: Thanks everybody.

Paul Jarris: Thank you.

Operator: And that concludes today conference. We thank you all for joining us.

Elisa Muntahli: Thank you, Sarah.

Operator: You're welcome.

END