The most common content type represented was that of a conceptual framework to guide activities that address a specific health need. Data sources were least common in this set. Most provided links to others' tools, measure domains, or data sources; however, many also provided tools that they helped develop — such as an interactive map or checklists — to support population health improvement. Some types were more likely to occur together. For example, conceptual frameworks to guide community engagement in improving population health were often paired with communities focusing on a specific health need.

Further details on the content types of each framework or initiative are provided in Appendix B.

An Abundance of Measure Domains, Measures, and Data Sources May be Counter Productive

Within the 40 frameworks and initiatives exists a wealth of measure domains, lists of measures and suggestions for possible data sources. This abundance creates a challenge, acknowledged in observations of a few of the frameworks and initiatives, because of the lack of coordination among the multitude of data sources, as well as the need for a coherent strategy to identify measure domains and a rational set of core population health measures that most stakeholders can agree upon. According to *A Healthier America 2013: Strategies to Move from Sick Care to Health Care in Four Years*, currently there are more than 300 different surveillance systems or information networks supported by the federal government for public health alone. Add to that the array of other data sources, some of which are noted in other frameworks:

- The increasing amounts of data in healthcare electronic medical records and registries
- Surveys such as the Gallup-Healthways Wellbeing Index, used by the *Blue Zones* project
- Information repositories on the health of specific populations, such as data on people in jails and prisons collected in the *Correctional Health Outcomes and Resource Data Set*
- Data for every county in the country, showing results for 75 to 200 measures available through the *Roadmaps to Health (County Health Rankings)* project
- A multitude of federal data sources maintained or referenced by the Centers for Disease Control, Census Bureau, Department of Education, Department of Transportation, Environmental Protection Agency, National Cancer Institute, and many others

There are also many measures and measure domains to consider. Examples include measures addressing environmental and social determinants of health, health- and quality-of-life measures for counties or communities, end of life assessment and measurement, school readiness measures that are "high power" due to being easily understandable by a range of stakeholders, community healthy living index (with domains addressing childcare, schools, neighborhoods, workplaces, community), leading health indicators, and a plethora of other measures or indicators related to healthcare, public health, and social services. There is no shortage of measures or measure domains from which to draw to inform the content of the *Action Guide*.

Aligning around key focus areas to assess, measure, and improve is assumed to increase the likelihood of positive impact; therefore, sharing data is foundational to the kind of coordination needed to effectively improve population health. In the current environment, the array of data and measure options — in absence of structural consistency or clarity — could be the reason why several of the initiatives describe having limited ways to measure population health. With so much out there, it is hard to identify what is most useful and meaningful. The *Action Guide* can assist with this; however, it will require parameters and structure to guide the selection of the most useful data sources, measure domains, and measures.

The Format of Tools Helps to Ensure Their Usefulness

Like measures and data sources, there is a range and depth of useful tools covering a breadth of topics. Among them, a common theme appears to be the format in which many of these resources are offered. Nearly all of the tools identified are available online, and many are dynamic and interactive. A couple of notable examples:

- The *Roadmaps to Health* initiative has expanded over time, from an extremely useful data source at its core (also known as the Wisconsin MATCH or County Health Rankings), to now offer a compendium of targeted and interactive tools to support communities engaging in population health improvement.

- The *Practical Playbook* is another tremendous resource for communities, offering a database of localized resources and an interactive planning tool, in addition to communication guides.

The array of tools available within the 40 frameworks is extensive. Some other examples:

- Planning materials for 501c3 hospitals to meet the IRS community benefit requirements (*ACHI Community Health Assessment Toolkit*)
- Health oriented pledge action checklists for individuals, employers, and community policymakers (*Blue Zones*)
- Management tools, online discussion forums, and checklists regarding sustainability, planning, scaling a project, and implementation (*Camden Cross Site Learning*)
- Technical assistance materials for jails wanting to measure and improve the health of their population (*CHORDS*)
- A communication framework and guidance (*Early Education Readiness*)
- Assessment sheets to evaluate safe and healthy relationships, along with community training materials and videos (*Wellness Warriors*)
- Interactive trackers for change over time, a database of 1800+ interventions to improve community health rated by the degree of evidence (*Healthy Communities Institute*)
- The Last Straw board game to educate community members about the social determinants of health, and toolkits for physicians to use with their patients (*Healthy Start, Healthy Future*)
- A patient assessment survey, template for a personalized care plan, and chart of care and services aligned with specific metrics (*Hennepin Health*)

- Lists of questions to understand the health implications of various policies, including how to think about and frame messaging to build support (*Health in All Policies*)
- Five Simple Steps guides for individuals, families, schools, community leaders, chefs, elected officials and doctors (*Let's Move*)

Similar to measures and data sources, development of the *Action Guide* will require early decisions about parameters and scope to enable selection of the most compelling tools for use by communities.

Specific Analysis and Cross Case Insights

In assessing the mix of frameworks, several specific insights came to light, raising key issues for consideration by the project Committee and others in shaping the *Action Guide*:

- Divergence in criteria may signal gaps to address in the framework for the *Action Guide.*
- Sustainability and scalability need further definition and parameters.
- Sustainability opportunities exist in changing structures and public policy.
- Use of understandable, culturally appropriate language is important.
- Stakeholder participation is varied, yet signals notable common gaps.

Each of these insights is described in further detail below.

Divergence in Criteria May Signal Gaps to Address in the Framework for the *Action Guide*

Several frameworks and initiatives suggested or applied somewhat distinct criteria that may be worth considering for the conceptual framework in the *Action Guide*. For example:

- **Attend to effective communication**. This includes shaping a compelling message and then communicating it in ways that work for others. For example, *Health in All Policies* includes guidance for how to talk about the importance of the work. The *AHCI Community Health Assessment* includes a communication toolkit. The *YMCA Pioneering Healthy Communities* suggests using data and results to convince partners and recruit volunteers. Several frameworks and initiatives use leading edge approaches such as social media and online, interactive graphics, and maps.

- **Plan to be adaptable**. *Pioneering Healthy Communities* and *Roadmaps to Health* both take a cyclical view of the work. One suggests "Plan, Act, Evaluate, Adjust" and the other promotes the "Take Action Cycle."

- **Deliberately engage individuals and families**. Several of the projects — in Alaska, the United Kingdom, Camden, and Los Angeles, for example — have specific activities to engage individuals and families directly in the planning and the work itself.

- **Take action to change policy**. Building on observations regarding the impact of policy on the ability to improve population health, several frameworks or initiatives specifically include this activity in their structure. Examples include *Operation Live Well* and the *Healthy Base Initiative*, *Roadmaps to Health*, and *Project Healthy Grad*, among others. For this potential criterion, *Health in All Policies* is a notable resource.

- **Other topics for consideration**: includes diverse areas such as workforce needs, information technology and exchange, equity and addressing cultural barriers, and reward and recognition.

Sustainability and Scalability Need Further Definition and Parameters

Guidance from the Committee included noting the importance of addressing both sustainability and scalability for the frameworks and initiatives included in this report. However, definitive assessment of each element requires a level of detail that is often unavailable publicly, and clear thresholds for determining that a framework or initiative is indeed sustainable and/or scalable would need to be established.

A framework or initiative may be sustainable because it recommends the creation of a sustainability plan, or has been designed in a way that it can continue through the foreseeable future. The *Practical Playbook* and *YMCA's Pioneering Healthy Communities* both describe such criteria using plain language, and include practical advice such as "Borrow from others and build your own" (meaning only build something new if you can't use what others have already created).

In the absence of detailed information, a clear definition, and specific parameters for what qualifies as sustainable, the project team took an inclusive approach to this analysis. If a framework or initiative recommended a sustainability plan, mentioned the existence of a business plan or sustainable model, and/or is funded by a multiyear grant or government program, it was considered to have met the sustainability criterion. That said, even multiyear grants and government funding eventually come to an end. Finally, the concept of sustainability was not always highly relevant, such as for the more conceptually orientated frameworks focused on measurement.

Similarly, assessment of "scalability" proved challenging. The ability to assess whether a program is scalable, or the degree to which it might be scalable if certain conditions exist, was largely beyond the scope of information and time available to the project team. A deeper assessment would be needed using information that was not available, including: a shared definition of scalability; specific parameters to apply in determining whether an initiative or framework is scalable; and a clear understanding of the types of frameworks and initiatives to which the question of scalability is applicable. For example, one could argue that scalability is not relevant to a report of recommendations for federal agencies, or a data source that provides data for all geographic areas in the country. Given this limitation, this report focused on when a framework recommends that programs are designed in ways that are scalable, or when a program/initiative describes how it can be replicated by others.

Sustainability Opportunities Exist in Changing Structures and Public Policy

Many of the frameworks and initiatives noted that sustainability is a challenge; however, opportunities exist. A common theme in a number of the frameworks and initiatives is to focus on changes that are structural in nature, to increase the likelihood that the change will be sustained. Examples include policy commitments, new patterns of care and coordination among stakeholders, and linking medical and public health information systems. In addition, several of the frameworks encourage connections with new opportunities in the current market. Examples include structures being developed or implemented such as Accountable Care Organizations, Accountable Health Communities, Patient Centered Medical Homes, community health improvement requirements for nonprofit hospitals, and Public Health

Accreditation. Frameworks or initiatives which address these types of opportunities include: *A Healthier America 2013: Strategies to Move from Sick Care to Health Care in Four Years; Correctional Health Outcomes and Resource Dataset; HCI CHNA System and Healthy Communities Network; Health in All Policies; Moving Healthy; National Prevention Strategy; White Earth Nation Tobacco Free Community; Primary Care and Public Health Exploring Integration;* and the *Guide to Community Preventive Services*.

Several of the frameworks call out serious gaps or needs that must be addressed in terms of the impact of public policy. While this might inform suggested areas for focus in the *Action Guide*, it is not clear whether a compendium of needed policy changes would be the most useful content for the intended audiences of the *Action Guide*. Some examples that include significant recommendations regarding public policy include: *For the Public's Health: The Role of Measurement in Action and Accountability*; *HHS Action Plan to Reduce Racial and Ethnic Disparities; Primary Care and Public Health: Exploring Integration; The Guide to Community Preventive Services; and, Toward Quality Measures for Population Health and Leading Health Indicators*.

Use of Understandable, Culturally Appropriate Language is Important

Consistent with the criteria gap noted earlier regarding the importance of effective communication planning, and engagement, a number of the frameworks and initiatives provide one or more definitions of commonly misunderstood terms, explain acronyms, use new terms to address a relevant topic, or directly address the importance of using words that are easy for everyone to understand.

A few of the less common terms defined in some of the frameworks include "environmental justice,"' "lifespace," and "performance triad." Lists of terms or acronyms and their definitions are in a number of examples, including *Health in All Policies; For the Public's Health: the Role of Measurement; Primary Care and Public Health: Exploring Integration;* and the *Beacon Community Program*. The most comprehensive and generally applicable list of terms, and therefore likely the most useful resource to start with, appeared to be captured within *Health in All Policies*.

The *YMCA Pioneering Healthy Communities* includes an excellent framework for using plain language, and a toolkit to support effective communication. *Toward Quality Measures for Population Health and Leading Health Indicators* referenced a list of nine quality characteristics for the public health system. Not only is this a useful definition in itself, the characteristics could also be used as a set of measure domains.

On a related note, several of the frameworks or initiatives noted the need to address cultural issues. Tribal concepts shaped the program approach of the *Wellness Warriors* and the *White Earth Tobacco Coalition*. The latter also provides very useful guidance regarding how to connect topics with cultural beliefs as a way to create compelling messages. The framework *Primary Care and Public Health: Exploring Integration* recognizes and attempts to bridge differences in the cultures of medical and public health systems. Examples included charts that contrast areas such as training approaches, perspective in levels of analysis, and funding sources.

Stakeholder Participation is Varied, Yet Signals Notable Common Gaps

One of the criteria used to select many of the frameworks and initiatives for this report was the expectation that at least two of the following groups be involved: public health, healthcare, and other stakeholders. Assessment of the specific types of stakeholders signaled two notable gap areas:

- The media was named as a key stakeholder in only one framework, yet many of the frameworks or initiatives specifically name the importance of effective communication and public education as a key to success in improving population health.
- Only about one third of the frameworks and initiatives specifically address equity or disparities reduction, and a roughly equal portion list minority groups as a key stakeholder. However, many of the health topics being addressed — including obesity, stable housing, diabetes, violence and abuse, cardiovascular health, education, access to and use of health services, and corrections — are often associated with societal inequity or disparities.

The most common stakeholder types mentioned were healthcare practitioners and facilities, public health departments, and other government social service agencies. Individuals, such as patients and family members, are also called out in many of the frameworks and initiatives. In contrast, consumer groups were mentioned less frequently, as were the involvement of schools, nonprofit social service groups, employers, multistakeholder alliances, churches, housing and/or health plans. Stakeholder types mentioned least often included tribes, the military, corrections and jails, and unions.

Key Considerations and Recommendations for the Action Guide

Building on the themes and insights described in this report, the following questions are designed to help determine the approach to and content of the *Action Guide*. This can be used as the content for a discussion guide for the project Committee and federal partners to address the range of issues important to inform the next steps of this project.

1) **Refining the conceptual framework to guide community engagement to improve population health:**

    a) Which additional criteria identified in this report should be added, if any?

        - Other potential criteria identified included: ensure effective communication; engage individuals and families; address changes in policy; include a cyclical approach to planning; address workforce issues; equity and cultural competency; and others.

    b) Are there thresholds that the Committee should apply to make decisions? (e.g., evidence from third party research versus promising experience-based practice versus good ideas)

There is also a fundamental divergence among the frameworks and initiatives: Frameworks often encourage communities to conduct local needs assessments and select their own priorities, yet many also attempt to focus community attention on certain priority topics. Nearly all of the frameworks or initiatives identified at least one priority topic to address.

2) **Frameworks for improving outcomes on priority health needs:** Should the *Action Guide* include a framework for addressing a priority health improvement topic (e.g., obesity, safety, shelter, educational achievement)? If so:

   a) How will the top priority be selected?

   b) Are there threshold criteria that should apply to make this decision (e.g., not a health condition, universally important, high impact)?

3) **Inclusion of measures, data sources, and tools**: Because the *Action Guide* is intended to include *content useful for implementation* (measures, data sources, tools, definitions), what approach should be taken to shape its content? Options include:

   a) Offer content that supports the *conceptual engagement framework* (e.g., measures of engagement process, broader data sources that could address a range of priorities, tools for community health needs assessment and sustainability, etc.), with no assumed priority topic(s)

      - **Pro**: Focuses the *Action Guide* on supporting communities in using the engagement framework; promotes community level decision-making (internal consistency); ensures that the *Action Guide* contains a reasonable (not overwhelming) amount of information

      - **Con**: Misses the opportunity to drive a shared focus on one or two priorities and make the *Action Guide* more useful for some communities

   b) Offer a *conceptual engagement framework*, plus a *framework for one priority topic* about which the *Action Guide* would include measures, data sources, and tools

      - **Pro**: Encourages a shared focus on the selected priority; offers a compelling example of how a priority topic might play out within a community; creates a challenging but possibly still manageable scope for the *Action Guide.*

      - **Con**: Selecting only one priority may be difficult; selected topic may not be a high priority for all communities; misses the opportunity to focus the supporting information on the important work of engaging a community in working together to improve population health.

   c) Offer a *conceptual engagement framework*, plus one or two priority topics about which the *Action Guide* would include measures, data sources. and tools

      - **Pro**: Encourages a shared focus on a selected priority or priorities; offers ideas for resources if the topics are also a priority for the community

      - **Con**: Selecting one or two priorities may be difficult; selected topic(s) may not be a high priority for a community; misses the opportunity to focus the supporting information on the important work of engaging a community in working together to improve population health

4) **Inclusion of identified implementation resources.**

The foundational step in this approach was to engage in a broad scan for frameworks and initiatives to potentially include in the report, resulting in a list of more than 700 frameworks and initiatives aiming to improve population health. While this was in process, the project team developed a draft description of the purpose and scope of this report to help define parameters for selecting the mix of frameworks and initiatives, and to establish shared expectations across everyone working on the project. The description included the definitions and suggested criteria to use in narrowing the focus to 40 frameworks and initiatives. The suggested definitions and criteria were drawn directly from foundational population health research commissioned by NQF in 2012.[1] The definitions are listed earlier in this report, in the section entitled *Key Terms and Assumptions* on page 6.

This draft was discussed with the Advisory Committee for guidance. Based on their input, sustainability and scalability were added to the original seven criteria, and the view of diversity expanded to reflect issues beyond geography alone. In addition, while it was a priority to include *evidence-based* frameworks, tools, data, and measures, the project team took a broad view of this concept given the scope of the project and variable evidence available. The final criteria, listed below, were designed to be applied at two levels: individual and collective.

Individual Criteria. The following five criteria were applied, in the following order, to determine which conceptual frameworks would be appropriate to include in the environmental scan. Criteria one and two were used to identify the *individual* conceptual frameworks most appropriate for inclusion in the environmental scan.

1. Must address health improvement for the total population or a subpopulation in way that involves at least two and ideally all three of the following:
    a. Clinical care system
    b. Government public health agency or initiative
    c. Stakeholder system/systems
2. Should include most or all of the following seven items. The text in brackets and italics may be considered optional to avoid being too stringent initially; however, if needed, this could be applied to prioritize among frameworks.
    a. An organizational planning and priority-setting process [*taking into account the needs of the subpopulations served as well as resources available for health improvement activities*]
    b. Use a health and needs assessment process appropriate to the unit of analysis or action level [*that includes the synergistic needs of all respective organizations*]
    c. An agreed-upon, prioritized subset of health improvement activities where the respective organizations will direct resources and/or develop capacities to deliver them [*effectively and equitably*]
    d. Responsibility for leading a health improvement activity (process, intervention, or policy activity) within the [*geopolitical*] area
    e. Selection of a [*an integrated and complementary*] set of measures and performance targets that reflect improvement in total population health outcomes, the determinants of health, and health improvement activities (processes, intervention, or policy activity)
    f. Use of the same prioritized indicators of intermediate and final health outcomes and determinants of health measured at the total population level, which are clearly linked

Appendix B
Matrix of the Type of Content in the 40 Frameworks and Initiatives

The table below indicates which specific elements are included in each of the 40 frameworks and initiatives. The letters in each column heading represent the following elements:

A. Conceptual Framework to Guide Community Engagement to Improve Population Health
B. Conceptual Framework to Guide Activities that Address a Specific Health Need
C. Data Source
D. Population Health Improvement Program Being Implemented
E. Measure Domains or Measures
F. Tool

Name of Framework or Initiative	A	B	C	D	E	F	Total
A Healthier America 2013: Strategies to Move from Sick Care to Health Care in Four Years		x					1
ACHI Community Health Needs Assessment Toolkit	x					x	2
Beacon Community Program				x			1
Blue Zones Project		x	x	x		x	4
Camden Care Management Program and Cross-Site Learning	x	x		x	x	x	5
Clinical-Community Relationships Measures Atlas		x			x		2
Community Transformation Grants	x	x		x			3
Correctional Health Outcomes and Resource Data Set		x	x	x	x	x	5
County Health Rankings & Roadmaps to Health	x	x	x		x	x	5
Early Education Readiness Using a Results-Based Accountability Framework		x	x	x	x	x	5
Family Wellness Warriors Initiative				x		x	2
For the Public's Health: The Role of Measurement in Action and Accountability	x	x	x		x		4

Name of Framework or Initiative	A	B	C	D	E	F	G	H	I	Total
Moving Healthy: Linking FHWA Programs and Health	x		x	x					x	4
National Prevention Strategy: America's Plan for Better Health and Wellness	x	x	x	x	x	x	x	GT	x	9
National Service Frameworks	x	x	x	x	x	x	x	GT		8
National Strategy for Quality Improvement in Health Care	x		x	x	x	x	x	GT	x	8
Operation Live Well	x		x	x				GT	x	5
Pioneering Healthier Communities	x	x	x	x	x	x		IN	x	8
Practical Playbook	x	x	x	x	x	x	x	IN	x	9
Primary Care and Public Health: Exploring Integration to Improve Population Health	x	x	x	x	x	x		IN, GR, GT	x	8
Project Healthy Grad	x	x	x	x	x	x	x	GR	x	9
Regional Equity Atlas 2.0 and Action Agenda	T	T	T	T	T	T	T		T	Tool
State Innovation Models Initiative (SIM)	x	x	x	x				GT	x	6
The Guide to Community Preventive Services	x	x	x			x		IN, GR	x	6
Toward Quality Measures for Population Health and Leading Health Indicators					x					1
Vermont Blueprint for Health	x	x	x	x	x	x	x	GT	x	9
White Earth Nation Tobacco Coalition	x	x	x	x	x	x	x	GR	x	9
Total	**31**	**23**	**33**	**27**	**24**	**20**	**21**	**30***	**37**	

* Subtotals for Column H, Sustainability:

- GT = Government funded or advocates/relies on government funding. Total = 11.
- GR = Grant funded or advocates/relies on grant funding. Total = 8.
- IN = Framework provides guidance or information on creating a sustainability plan. Total = 10.
- SP = Includes, relies on or suggests a sustainability plan or model. Total = 1.

Appendix D
Individual Snapshots of Each Framework or Initiative

1. A Healthier America 2013: Strategies to Move from Sick Care to Health Care in Four Years

This report sets forth public health-related actions that should be taken at the federal, state, and local levels to shift from focusing on illness to promoting health. The report offers a variety of ideas for policy direction and priorities and actions, citing various other reports in addition to examples of successful public health programs across the country. Connections are explored between key initiatives and programs, with an emphasis on the potential for increased use and alignment of information technology to amass and share data. The framework suggests Public Health Accreditation Board (PHAB) accreditation standards in 12 domains: 10 essential public health services; management and administration; and governance.

The recommendations are intended for use by all federal, state, tribal, and local health departments, who are encouraged to partner with various stakeholders within and outside of healthcare: specifically nonprofit hospitals, public and private payers, and public- and private-sector employers.

http://healthyamericans.org/report/104/

2. ACHI Community Health Assessment Toolkit

The ACHI Community Health Assessment Toolkit is a guide for planning, leading, and using community health needs assessments to better understand and improve the health of communities. It presents a suggested assessment framework consisting of six steps, and provides guidance drawn from experienced professionals and a variety of proven tools to determine and address the health needs in a given community while satisfying the IRS 501C3 requirements for nonprofit hospitals.

The framework includes questions for communities to ask to define and assess their goals, provides suggestions on how communities might find and use data for measurement and indicators, and offers guidance on how to find needed information to assess health needs in a region. Information is intended for use by local hospitals and health systems, health coalitions and partnerships, public health departments, "healthy communities" organizations, local health foundations, and community health centers. Since IRS 501c3 rules apply to all nonprofit hospitals in the country, this toolkit is intended to be scalable to help those hospitals meet the requirements. However, only members can access the toolkit.

Tools include checklists, budgets, and timeline guides and templates for each of the six steps in the framework, with specific guidance on skills needed, budget drivers, time drivers, and a task checklist. Also included is a section dedicated to effective communication about needs, health improvement activities, and assessment results.

http://www.assesstoolkit.org/

3. Beacon Community Program

The Beacon Community Cooperative Agreement Program focuses on how health IT investments and Meaningful Use of electronic health records (EHR) can advance the vision of patient-centered care, while achieving the three-part aim of better health, better care at lower cost. The program was

established under the American Recovery and Reinvestment Act as part of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HHS Office of the National Coordinator for Health IT is providing $250 million over three years for programs currently operating in 17 communities, all of which have provided indicators of progress on their goals. Each community is focused on building and strengthening the health information technology (HIT) infrastructure; translating investments in health IT to measurable improvements in cost, quality and population health; and developing innovative approaches to performance measurement, technology and care delivery.

These communities are engaging non-traditional partners by establishing connectivity with schools, public health agencies and other stakeholders. The communities are also working on sustainability, with a focus on engaging employers and CFOs from major stakeholders, estimating return on investment (ROI) and developing sellable applications for analytics and care coordination. Aligning community goals is also a focus; communities are encouraged to gain understanding of other community projects and seek opportunities for synergy while avoiding competition. The results of the Beacon Community Program are intended to inform efforts nationally to support the meaningful use of Electronic Health Records (EHRs). The Beacon Evidence and Innovation Network was established to work with the communities in identifying, documenting and disseminating the lessons and results of each program, with the goal of establishing actionable evidence and strategies for wider implementation.

The program has also explored mobile health in text messaging pilot project aimed at diabetes risk reduction and disease management, which engages vulnerable populations in education campaigns and progress tracking initiatives. Topic focus areas for the communities include diabetes, lung disease, heart disease, asthma, rural health, preventable hospital readmissions, use of emergency services, racial health disparities, smoking cessation, healthy behaviors and care coordination

http://www.healthit.gov/policy-researchers-implementers/beacon-community-program

4. The Blue Zones Project

Based on research into communities around the world with the highest number of centenarians, the Blue Zones Project developed a set of nine principles intended to nurture a healthy and happy lifestyle. A team of demographers, medical researchers, anthropologists, and epidemiologists looked for evidence-based common denominators in five places around the world identified as having the highest life expectancy. The results present a conceptual framework of health improvement principles that can be followed by individuals as well as a broad range of community stakeholders. The “Power 9 Principles” focus on healthy actions and behaviors as well as the social settings that are most conducive to health, such as belonging to a faith community and being part of social circles that promote and aspire to healthy living.

These principles represent the ideal, rather than a plan of action or a set of specific interventions. Yet this project suggests that making efforts toward those ideals has the potential to influence health as much, if not more, than specific clinical interventions.

The Blue Zones Project focuses on encouraging individuals and community members to aspire to these healthy lifestyle ideals rather than follow a set of specific interventions. An online community provides guidance and tips ranging from healthy eating to stress management, and the project also includes “policy pledge actions” for schools, workplaces, local government entities, and communities pertaining

to the physical environment, food, and smoking. Success in both cases is determined by participation and effort rather than the achievement of specific goals.

Official Blue Zones communities, however, are being measured by the Gallup-Healthways Well-Being Index, which is based on subjective telephone surveys pertaining to physical and emotional health, health behaviors, work environment, basic access, and an overall life evaluation. At the beginning of each community project, Gallup conducts a survey of the community, an “oversampling,” to establish a baseline. The community is then benchmarked against the congressional district, other MSAs, the state, and nation. Gallup conducts surveys to update the data as the program progresses. The results are compiled and published, ranking communities across the country based on five elements of well-being: purpose, social, financial, community, and physical. [More information is needed as to how these communities have been affected by following Blue Zones guidelines.]

https://www.bluezonesproject.com/

5. Camden Care Management Program & Cross Site Learning

The framework from the Camden Coalition of Healthcare Providers encourages local groups to bring a range of stakeholders together to define problems and develop targeted interventions. The Cross-Site Learning initiative focuses on community initiatives that care for high-utilizing patients, or “super-utilizers,” with the goal of reducing unnecessary hospital use and reducing costs. The program has developed a comprehensive database to analyze and quantify the utilization of hospitals by Camden residents. This tool relies heavily on data from the Camden’s Health Information Exchange (HIE) to target and coordinate care for patients who lack consistent primary care and often suffer from chronic illness, mental illness, and substance abuse. The Cross Site Learning program is being implemented in 10 cities. Tools, planning guides, and other materials are being provided to expand "hot spotting" to other locations.

The framework provides general recommendations regarding use of data, in addition to materials explaining why risk stratification is important. To help similar programs thrive, a set of resources have been developed to provide guidance on planning a super-utilizer program pilot, implementing the pilot project and beginning to see patients, and scaling the project and building financial sustainability. As result of the program, new patterns of care transitions and care coordination are being developed between Camden’s hospitals and two Federally Qualified Health Centers. No specific evidence for the development of the framework or program is cited.

http://www.camdenhealth.org/

6. Clinical-Community Relationships Measures Atlas

This measurement framework lists existing measures for clinical-community relationships and explores ways to define, measure, and evaluate programs that are based on such relationships for the delivery of clinical preventive services. The framework references various sources throughout. Development of the recommendations included input from experts in the field and an environmental scan identifying existing measurement structures.

The framework for understanding the measurement of clinical-community relationships is designed to be scalable for implementation by researchers, evaluators, primary care clinicians, and community

organizations involved in providing prevention services to patients. Measures are based on a number of assumptions about clinical-community relationships, as described in the report, including the centrality of the primary care role; a distinction between clinics or clinicians and community-based resources; the focus on primary and secondary prevention strategies consisting of counseling or screening services provided in community resource settings; an approach to prevention that includes both primary and secondary strategies; the exclusion of patient health outcomes to focus on the function of clinical-community relationships; and the exclusion of any measures that require a fee to access. The list of existing measures includes detailed information on the measure's purpose, format and data source, validation and testing, applications, and key sources. The Master Measure Mapping Table provides an overview of domains and the relationships involved.

http://www.ahrq.gov/professionals/prevention-chronic-care/resources/clinical-community-relationships-measures-atlas/index.html

7. Community Transformation Grants

Through the Community Transformation Grant (CTG) Program, CDC supports and enables awardees to design and implement community-level programs that prevent chronic diseases such as cancer, diabetes, and heart disease. All grantees work to address the following priority areas: 1) tobacco-free living; 2) active living and healthy eating; and 3) quality clinical and other preventive services, specifically prevention and control of high blood pressure and high cholesterol. Grantees may also focus on creating healthy and safe environments and reducing health disparities. The program is already operating on a large scale, and various accomplishments have been reported. Each program has specific goals but information is not readily available about specific measures being used across communities.

In 2012, CTG was expanded to support areas with less than 500,000 people in neighborhoods, school districts, villages, towns, cities, and counties to increase opportunities to prevent chronic diseases and promote health.

http://www.cdc.gov/nccdphp/dch/programs/communitytransformation/

8. County Health Rankings & Roadmaps to Health

The County Health Roadmaps is an interactive framework ("The Action Cycle") for organizing and planning initiatives, projects, and collaborative actions aimed at population health improvement. The County Health Rankings is a tool rating the health of the population by county, based on health factors identified in a population health model that includes the policies and programs and health factors affecting health outcomes. The evidence used to develop these frameworks is explained in a working paper.

The stakeholder types included in the framework are as suggested collaborators and/or project initiators in healthcare, public health, business, educators, philanthropy, and government. The framework provides guidance on how each type of community member can be involved in population health improvement. Scalability is a key element to the project, which uses interactive graphics and also utilizes social media to share news and information.

Key underlying lessons presented by the project include the following:

- Much of what influences healthcare happens outside the doctor's office.
- Health insurance and quality healthcare are important, but we need leadership and action beyond healthcare.
- Using community data to determine needs, everyone can play a role in improving population health.

The framework does not include information on specific domains of measurement, but refers to the Health Indicator Warehouse. The County Health Rankings aspect of the project synthesizes health information from a variety of national data sources to create an interactive database. The initiative then uses the conceptual model of population health improvement to weigh and rank the data, thereby creating a form of new data.

The website provides access to a guide to evidence-based policies, programs and system changes ("What Works for Health") and a "Tools & Resources" page with external links to educational materials and additional tools. The website also presents examples of projects and initiatives that have used the County Health Rankings & Roadmaps to approach population health improvement.

http://www.countyhealthrankings.org/

9. Correctional Health Outcomes and Resource Data Set

CHORDS is a quality improvement initiative that provides data for comparison of clinical processes and outcomes. CHORDS consists of: standardized performance measures, with an emphasis on effectiveness of care; availability of and access to care, use of services, and cost of care; a data repository to establish regional and national benchmarks; and data reporting capabilities to help correctional systems track, trend, and compare data over time.

The project focuses on care within correctional facilities and aligning measures with those used in "mainstream" care. Services are free and accessible, but an electronic medical record or other means to readily extract and export data is suggested. The project includes standardized performance measures, with an emphasis on effectiveness of care, availability of and access to care, use of services and cost of care. The project has the potential to spearhead alignment for populations going into and/or coming out of incarceration.

The approach is modeled on HEDIS measures. Data is supplied by jails and other correctional facilities. For example, for the first measures, data were submitted by 66 participants—56 prisons and 10 jails; of these, 59 were single-site entities. The first nine performance measures, all related to diabetes, have been developed and the first test of the system has been conducted. The project is now moving into phase 2, developing new measures for other health conditions and then collecting data. Program goals to create and expand the system are being met.

http://www.ncchc.org/chords

10. Early Education Readiness Using a Results-Based Accountability Framework

This framework establishes school readiness indicators in Los Angeles County, as defined by a collaborative of child-serving organizations such as First 5 LA, the Children's Planning Council and the Los Angeles County Public Health Department, as well as parents and families. The Los Angeles County

School Readiness Indicator (SRI) Workgroup convened to develop goals and indicators, with three objectives: 1) engage many agencies and individuals working with young children and families in communities throughout the county; 2) use understandable indicators to provide a results-based accountability framework for partnering organizations to align resources and action toward common goals; and, 3) use indicators to monitor trends in conditions for school readiness over time.

The framework used the National Education Goals Panel's (NEGP's) working definition of school readiness: children's readiness for school, school's readiness for children, family and community supports and services that contribute to children's readiness for school success. Indicators were also chosen to reflect the five outcomes adopted by Los Angeles County: good health; safety and survival; economic well-being; social and emotional well-being; and education/workforce readiness.

School readiness goals deemed important by the workgroup were included in the final indicator set regardless of the availability of ideal data. A data development agenda was developed to encourage future work on indicators for these hard-to-measure goals.

http://www.cdc.gov/pcd/issues/2007/oct/07_0073.htm

11. Family Wellness Warriors Initiative

The Family Wellness Warriors Initiative (FWWI) is a program that provides training to Alaska-Native community members to prevent domestic violence. The program targets behaviors by focusing on domestic violence and child abuse and providing personal tools for healthy and safe relationships.

The initiative works with communities to implement a three-year model designed for Alaska-Native areas. The model was developed by group of 30 stakeholders who researched internationally for programs pertaining to domestic violence and abuse. The FWWI program was adapted from the SALTS program in Michigan by a Steering Committee of Alaska-Native people and mental health professionals. The model is designed for scalability within Alaska-Native areas, since it is designed specifically to be culturally relevant to these communities. While the specifics of the program may not be scalable outside of Alaska-Native areas, the process behind the development of culturally specific initiatives could be replicable, along with lessons learned and insights from the program. The program provides trainings for the community upon request and the website provides links to local anti-violence resources, including counseling centers. A video series shows on the impact of violence and abuse, and how the initiative is tackling the problem.

For progress tracking, an internal evaluator is used and three domains are measured, including personal growth and family cohesion. (Information on the third domain is pending.) Sub-domains include measuring anxiety, depression, substance abuse, anger, cultural connectedness and spirituality. FWWI also uses its own scale, the family wellness scale, measuring predefined outcomes based on the curriculum. All of the program targets are aligned with the corporate objectives of the umbrella organization, the Southcentral Foundation's NUKA System of Care.

http://www.fwwi.org/

12. For the Public's Health: The Role of Measurement in Action and Accountability

This Institute of Medicine review examined current approaches for measuring health and suggested changes in the processes, tools, and approaches used to gather information about health outcomes and determinants of health as part of the overarching need for a national data reporting and collection system. As a conceptual framework, the report provides context and guidelines for measurement that could be implemented at the governmental public health level as well as through other health-system stakeholders. However, specific recommendations are targeted at the national government public health system, namely the Department of Health and Human Services.

The report cites multiple sources as part of its analysis and recommendations and provides a list of measure domains that could be used as a planning resource for population health improvement projects and initiatives. Measurement domains cover several national sources of indicator data, such as Healthy People 2020, State of the USA, Trust for America's Health, America's Health Rankings, County Health Rankings, and Community Health Status Indicators. Data sources are listed for each of the measure sets.

Stakeholders are defined in the report as communities and their organizations, the clinical care delivery system, employers and businesses, the media and other public and private entities whose policies and actions affect the longevity and quality of life for Americans. A list of acronyms provide context for the various entities and initiatives referenced in the report, and charts provide a visual resource comparing measurement domains in national data sources and at the local data source level.

http://www.iom.edu/Reports/2010/For-the-Publics-Health-The-Role-of-Measurement-in-Action-and-Accountability.aspx

13. Green Strides

Green Strides is a U.S. Department of Education initiative aimed at making all schools healthier, safer, and more sustainable with programs in the areas of facilities, health, and environment. Online resources include a webinar series, a blog, and a social networking account to facilitate the sharing of best practices and resources. The resources page also lists tools for schools, teachers, parents, and students to use in the planning and execution of environmental improvement strategies, such as reducing environmental impact and cost, promoting health and wellness, and learning about environmental sustainability.

The webinar series and online resources are designed to move schools toward the recognition program, "Green Ribbon Schools." This award recognizes exemplary efforts in reducing environmental impact and costs; improving the health and wellness of students and staff; and providing effective environmental and sustainability education, which incorporates STEM, civic skills, and green career pathways. The award is designed to be a tool to encourage state education agencies to consider matters of facilities, health, and environment comprehensively and in coordination with their state health, environment, and energy counterparts. The initiative is based on a broad partnership between various government entities and private organizations and does not include definitive goals or progress reports.

http://www2.ed.gov/about/inits/ed/green-strides/index.html

14. The Guide to Community Preventive Services

The Community Preventive Services Task Force (Task Force) was created by the U.S. Department of Health and Human Services to identify population health interventions that are scientifically proven to save lives, increase lifespans, and improve quality of life. Recommendations of the Task Force are available in the Guide to Community Preventive Services, a free resource to help identify programs and policies to improve health and prevent disease in the community. Systematic reviews are used to explore proven program and policy interventions, effective interventions for specific communities, and the cost and potential return on investment of interventions. The project uses various data sources to evaluate interventions, and recommendations are designed to be scalable and relevant. Examples of programs that use the Community Guide are shown on the website, although specific data regarding achieving results is not provided.

A key component of the Task Force's work is to identify gaps in the evidence base, while providing guidance as to how those gaps can be filled by targeted research and evaluation of frameworks. As a tool, the Community Guide provides guidance on: programs and services; policies; education; funding; research; evidence gaps; and public health improvement and accreditation.

http://www.thecommunityguide.org/

15. HCI CHNA System and Healthy Communities Network

The Healthy Communities Network (HCN) is a customizable web-based information system designed to provide access to data and decision support for use in health indicator tracking, best practice sharing, and community development. The program utilizes data from online sources such as the National Cancer Institute, Environmental Protection Agency, U.S. Census Bureau, U.S. Department of Education, and other national, state, and regional sources. Although the program is designed to be scalable, users must pay to use the system.

The database includes more than 75,000 quality of life indicators for any community, and also comprises more than 1,800 “promising practices” or actions to improve population health. Those that are research or evidence-based are distinguished as such, while others are categorized as a “promising practice” or “good idea.” The information in the database is updated frequently, providing a continually expanding resource. Trackers built into the system help evaluate the effectiveness of the local group's programs and the health of the community using this system, compared against local and national goals. HCI won the MyHealthyPeople Award in the U.S. Department of HHS Developers Challenge.

http://www.healthycommunitiesinstitute.com/

16. Health Impact Pyramid

This five-tier pyramid describes the impact of different types of public health interventions and provides a framework of activities most likely to improve population health, citing a variety of reports and other references. The framework emphasizes the significant potential population health impact that addressing social determinants of health can have compared to activities like counseling and individual-level education.

Although the framework is not focused on measurement, it does state the need for comprehensive public health programs to attempt to implement measures at each level of intervention to maximize synergy and the likelihood of long-term success. Multistakeholder involvement is broadly addressed, but specific guidance or recommendations are not provided.

http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2009.185652

17. Health in All Policies: A Guide for State and Local Governments

Health in All Policies is a framework that identifies the ways in which decisions in multiple sectors affect health, and how better health can support the goals of these multiple sectors. It emphasizes the need to engage diverse governmental partners and stakeholders to work together to promote health, equity, and sustainability, and simultaneously advance other goals such as promoting job creation and economic stability, transportation access and mobility, a strong agricultural system, and educational attainment.

The framework draws heavily on the experiences of the California Health in All Policies Task Force and incorporates information from the published and gray literature. Various research is cited throughout the report. The stated goal of the framework is to ensure that decision-makers are informed about the health, equity, and sustainability consequences of various policy options during the policy development process. However, no information is provided about whether or not that goal is being met by those using the report.

Using the Healthy Community Framework, "Health in All Policies" has identified specific ways to measure each of the elements in the framework, which includes 20 pages of domains and measures, with alternate approaches. The focus is on domains that support the definition of a "healthy community" as one that meets the basic needs of all; includes quality and sustainability of environment; has adequate levels of economic and social development; demonstrates health and social equity; and fosters social relationships that are supportive and respectful. The framework is intended for use by state and local governments across the country and includes a glossary of commonly used terms. Tools include:

- "Food for Thought"—Lists of questions that leaders of a Health in All Policies initiative might want to consider
- Tips for identifying new partners, building meaningful collaborative relationships across sectors, and maintaining those partnerships over time
- More than 50 annotated resources for additional support

http://www.phi.org/resources/?resource=hiapguide

18. Healthy Base Initiative Demonstration Site — Ft. Meade, MD

Started in September 2013, this is a one year demonstration program of the Department of Defense's "Operation Live Well" initiative. The aim is to assess best practices and lessons learned at this military base, along with 13 other bases appointed by the DOD, to promote healthier and more resilient service members, families, retirees, and civilian employees. Teams of subject matter experts will evaluate Ft. Meade's facilities and programs, covering everything from fitness and wellness programs offered to available food choices. The demonstration focuses primarily on what is driving obesity and tobacco use.

The baseline review will help to clarify the programs currently in place and determine how to improve outcomes resulting in more physically and emotionally strong military and family members. DOD will then develop policies for the future that can be shared across the military and beyond installation gates. Stakeholders include military base leaders and related providers, restaurants and food vendors, and a newly opened wellness center. Affiliated tools are provided through Operation Live Well and the military health department, but none is specific to the Ft. Meade demonstration.

http://www.defense.gov/news/newsarticle.aspx?id=120796

19. Healthy Memphis Common Table

This collaborative of community partners runs multiple population health improvement projects, including the Million Calorie Reduction Match, which encourages businesses and organizations to improve the health of employees and members by introducing and encouraging healthier choices and activities. The projects include elements that appear to be scalable, such as health improvement activities, policy guidelines, and the composition of the multistakeholder partnerships involved.

As an AF4Q-funded initiative, the work of the Healthy Memphis Common Table is based on the research and guidelines of the County Health Rankings & Roadmaps program through the Robert Wood Johnson Foundation (RWJF). Using the data compiled by RWJF, the Healthy Memphis Common Table examined health rankings for the community and developed a program aimed at addressing target problem areas. The initiative is focused on improving the quality of primary care; empowering patients and caregivers; fighting childhood and family obesity; reducing diabetes, heart disease, and pediatric asthma; and eliminating food deserts in low-income neighborhoods.

While the Healthy Memphis Common Table does not provide a specific framework for emulation, elements of the initiative's principles and projects could be adapted to various other communities. The collaborative aspect of the initiative is particularly viable; Healthy Memphis Common Table has partnerships with around 1,000 individuals from 200 organizations in the community. Stakeholders run the gamut and include individual consumers, schools, hospitals, physicians, nurses, nutritionists, dentists, and other healthcare providers, medical advocacy and support groups, insurance executives, health plans, quality improvement organizations, colleges and universities, businesses and employers, government, media, youth groups, faith-based organizations and churches, health-, fitness- and recreation-related affiliates, and nonprofit agencies and foundations. Healthy Memphis Common Table serves as a convener in that respect, bringing seemingly disparate elements of the community together to take a comprehensive view of health.

The collaborative produces public reports on healthcare value in the area, targeting issues such as the quality of healthcare for Medicare patients and health disparities in the community. Status reports also provide insight into efforts to reduce childhood and family obesity, potentially avoidable hospitalizations, non-urgent emergency department visits, and the quality of care in primary practices. These reports are intended as a public tool.

http://www.healthymemphis.org/af4q.php

20. Healthy People 2020

Healthy People is a set of goals and objectives with 10-year targets designed to guide national health promotion and disease prevention efforts in the U.S. The framework relies on a vast variety of data sources, which are listed on the Healthy People 2020 website, and brings together a wide variety of stakeholders to identify nationwide health improvement priorities; educate the public; engage multiple sectors in action; and provide measurable objectives at local, state, and national levels. The framework is already implemented on a broad scale and progress reports suggest mixed results, but success in some areas.

The initiative identifies a smaller set of Healthy People 2020 objectives called "Leading Health Indicators," selected to community high-priority health issues and actions that can be taken to address them.

Four foundational health measures have been identified to monitor progress toward promoting health, preventing disease and disability, eliminating disparities, and improving quality of life. Domains include general health status, health-related quality of life and well-being, determinants of health, and disparities. Measures and sources are included for each. Educational materials for understanding and implementing the framework are available online. Tools include a database of evidence-based resources, planning guidelines, funding resources, tools for health care professionals, and webinars.

http://www.healthypeople.gov/2020/default.aspx

21. Healthy Start, Healthy Future for All

This regional coalition leads projects to improve the health of families through education, encouraging healthy lifestyle choices and providing resources. As an AF4Q project, the initiatives and priority actions are based on the research and guidelines of the County Health Rankings & Roadmaps program through the Robert Wood Johnson Foundation.

Various stakeholders are involved in the collaborative and its projects, which include providing healthy weekend meals to schoolchildren as a way of improving mental and physical health and creating "baby cafes" — drop-in centers providing free, skilled lactation care to new mothers.

The project creates educational materials and toolkits, such as The Maternal Infant Resource Guide; "The Last Straw" board game demonstrating how social determinants impact health; An Ounce of Prevention is Worth a Pound—a physician toolkit to assist in delivering evidence-based messages to parents in order to prevent childhood obesity; and Healthy You x2—a physician toolkit that promotes healthy pregnancies and healthy babies.

Information on specific performance targets and progress is not publicly available, but is overseen by the initiative's funders. The goals are often developed by organizations that are unfamiliar with using population-wide goals and that are unsure of data sources. As a result, many goals focus on policy and systems changes, rather than actual health metrics. However, media coverage suggests that the Healthy Start, Healthy Future for All initiative is making a positive impact on the community.

http://forces4quality.org/healthy-start-healthy-future-all-program

22. Hennepin Health

This pilot program seeks to integrate medical, behavioral health, and human services in a patient-centered model of care. The aim is to improve health outcomes and lower the total cost of providing care and services to a population of more than 200,000 served within the Hennepin County cooperative network. The initiative is led by the public health department but involves healthcare and other stakeholders, such as corrections.

The program uses an integrated data warehouse and analytics infrastructure to support timely, actionable feedback to members, providers, and administrators and to align metrics across medical care, public health, and social service providers. Metrics specifically address goals to: reduce hospitalizations; increase compliance to keep chronic diseases in control; reduce emergency department visits; reduce detox utilization; assist with a safe and stable living situation; increase functional skills/independence; decrease substance abuse; decrease health risk factors; assist with a healthy natural support system; and maintain Medicaid eligibility for each enrollee.

Evidence from other social service programs was used to structure the program. This project measures Medicaid costs, and healthcare costs beyond the medical assistance benefit set, including uncompensated care, human services, and public health costs. The framework cites evidence from an array of programs that have worked on addressing health issues for the target population.

http://www.hennepin.us/healthcare

23. HHS Action Plan to Reduce Racial and Ethnic Disparities

This plan outlines the goals and actions that the U.S. Department of Health and Human Services (HHS) will take to reduce health disparities among racial and ethnic minorities. As a framework, the action plan provides background information on the issue, an overview of current national initiatives, and basic guidance on strategic considerations and priorities, but the details of the plan are specific to HHS.

The action plan is based on national goals and objectives for addressing health disparities identified by the Healthy People 2020 initiative and focuses on evidence-based programs and best practices. Stakeholders include public and private partners of HHS, as well as other federal partners collaborating on the initiative, including the Departments of Agriculture (USDA), Commerce (DOC), Education (ED), Housing and Urban Development (HUD), Labor (DOL), Transportation (DOT), and the Environmental Protection Agency (EPA).

The following set of key disparity measures are included in the action plan, tied to the initiative's high-level goals:

I. Transform Health Care

- Measure 1: percentage of the U.S. nonelderly population (0-64) with health coverage
- Measure 2: percentage of people who have a specific source of ongoing medical care
- Measure 3: percentage of people who did not receive or delayed getting medical care due to cost in the past 12 months
- Measure 4: percentage of people who report difficulty seeing a specialist
- Measure 5: percentage of people who reported that they experienced good communication with their healthcare provider

- Measure 6: Rate of hospitalization for ambulatory, care-sensitive conditions
- Measure 7: percentage of adults who receive colorectal cancer screening as appropriate

II. Strengthen the Nation's Health and Human Services Infrastructure and Workforce

- Measure 1: percentage of clinicians receiving National Health Service Corps scholarships and loan repayment services
- Measure 2: percentage of degrees awarded in the health professionals, allied, and associated health professionals fields
- Measure 3: percentage of practicing physicians, nurses, and dentists

III. Advance the Health, Safety, and Well-Being of the American People

- Measure 1: percentage of infants born at low birth weight
- Measure 2: percentage of people receiving seasonal influenza vaccination in the last 12 months
- Measure 3: percentage of adults and adolescents who smoke cigarettes
- Measure 4: percentage of adults and children with healthy weight

http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=285

24. HRSA Public Health Steering Committee Recommendations

The Health Resources and Services Administration (HRSA) Public Steering Committee developed 11 recommendations grouped into five strategic categories that drive the HRSA Public Health agenda: achieving health equity; linking/integrating public health and primary care; strengthening research and evaluation, assuring availability of data and supporting health information exchange (HIE); assuring a strong public health and primary care workforce; and increasing collaboration and alignment of programs within HRSA and among its partners.

The recommendations provide a framework specific to HRSA as a leader in strengthening the public health system. Information in the report was based on analysis of evidence-based public health resources and input from a variety of stakeholders, including individuals across HRSA and public and private organizations committed to improving population health. Collaboration with stakeholders was identified as the means to bridge the gap between public health and clinical care, and to develop new and promising strategies and systems that create a better trained workforce and more coordinated programs.

The report offers insight into the process to determine strategic priorities and actions but focuses on identifying opportunities rather than establishing a specific plan. During the process, the Committee adopted a working definition of public health: "What we as a society do collectively to assure the conditions in which people can be healthy" (cited as IOM, 2002).

http://www.naccho.org/topics/hpdp/upload/phsc-report_final.pdf

25. Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014

This set of strategic initiatives provides a framework to support the mission and vision of the Substance Abuse and Mental Health Services Administration. Each initiative targets a specific purpose and provides goals, action steps, and measures for determining success both internally for SAMHSA and overall for population health improvement. As such, the framework could be used as a guide for various communities and entities with an agenda targeting substance abuse and mental illness.

The framework cites various sources as evidence for its strategic concepts, including the World Health Organization, the Center for Substance Abuse Prevention, and articles by professionals in the field. The initiatives target various stakeholders, including at the community level through individuals, families, schools, faith-based organizations and workplaces; the health care field through health, behavioral health, and related systems; the criminal and juvenile justice systems; the military; and entities providing permanent housing, employment, and education.

In terms of public tools, SAMHSA provides resources and guidance on its website focused on prevention of substance abuse and mental illness, trauma and justice, military families, health reform, health information technology, public awareness and support, data outcomes and quality, and recovery support. These include access to data tools, educational and informational materials, and links to external organizations.

http://store.samhsa.gov/shin/content/SMA11-4629/01-FullDocument.pdf

26. Let's Move!

Let's Move! is an executive initiative dedicated to solving the problem of childhood obesity. The framework is based on five pillars: creating a healthy start for children; empowering parents and caregivers; providing healthy food in schools; improving access to healthy, affordable foods; and increasing physical activity. Evidence-based recommendations are included for increasing activity and improving nutrition, and the initiative is already being implemented through various projects and programs nationwide in addition to being promoted as a voluntary program for individuals. The program emphasizes that everyone has a role to play in reducing childhood obesity, including parents and caregivers, elected officials from all levels of government, schools, healthcare professionals, faith-based and community-based organizations, and private sector companies. Various milestones and achievements are cited in the initiative's annual report. No specific measures are provided, but the Let's Move website provides "5 simple steps" guides for parents, schools, community leaders, chefs, children, elected officials, and healthcare providers on how to play a role in preventing and reducing childhood obesity and living and promoting healthier lifestyles. The website also includes educational materials for printing and distribution within communities.

http://www.letsmove.gov/

27. Moving Healthy: Linking FHWA Programs and Health

The document developed by the U.S. Department of Transportation Federal Highway Administration (FHWA) lays out the health-related strategies and goals being implemented in transportation projects and processes nationally and on a community level. While the FHWA does not have a single, specific program that focuses solely on health, it claims that health is implicit in a broad range of existing programs. The transportation planning process is outlined, and the framework references a variety of programs and initiatives based on research and analysis of data.

An example of measurement domains can be found in the FHWA's Environmental Review Process. FHWA uses the National Environmental Policy Act (NEPA) review process to determine the social and environmental impacts of transportation projects. Several key metrics evaluate the potential human health outcomes and impacts, including: air quality; noise; safety; continued access to existing parks,

recreational, and cultural resources; environmental justice; water quality; and access to safe transportation systems.

A variety of tools are referenced, including resources created by FHWA that are intended to help both transportation professionals and health practitioners identify and address the health impacts of transportation. As an entity that oversees the implementation of certain health-related requirements and legislation, the FHWA recognizes its unique position to promote these policies and impact population health by ensuring healthy environments and safe transportation.

http://www.fhwa.dot.gov/planning/health_in_transportation/resources/moving_healthy.cfm

28. National Prevention Strategy

The National Prevention Strategy integrates prevention recommendations from a variety of sources and identifies four strategic directions and seven targeted priorities as part of a national framework. The initiative aims to create healthy and safe communities, expand clinical and community-based preventative services, empower people to make healthier choices, and eliminate disparities. The strategy uses Healthy People 2020 as a foundational resource and provides recommendations based on the latest scientific research along with an appendix of justifications. The framework is designed for national implementation and is already broadly scaled.

Partnerships are a key element to the National Prevention Strategy, which emphasizes the need for stakeholders in state, tribal, local, and territorial governments; businesses; healthcare; education; community; and faith-based organizations. These partners play roles as policymakers, employers, funders, purchasers, data collectors and researchers, healthcare providers, and communicators and educators.

Key indicators are provided for the overarching goal, the leading causes of death, and each strategic direction and priority. The strategic directions include:

- Healthy and safe community environments
- Clinical and community preventive services
- Empowered people
- Elimination of health disparities

The priorities include:

- Tobacco-free living
- Preventing drug abuse and excessive alcohol use
- Healthy eating
- Active living
- Injury and violence-free living
- Reproductive and sexual health
- Mental and emotional well-being

Each indicator includes information on the data source, the frequency of data collection, a baseline statistic, and a target for 2030, with an explanation of methodology.

Annual status reports explore the various programs and initiatives implementing the National Prevention Strategy, information on the stakeholders involved and their roles, and National Prevention Council actions and commitments for the future. The reports also provide the most recent statistics for all of the identified key indicators, showing positive progress in the majority of areas.

http://www.surgeongeneral.gov/initiatives/prevention/strategy/

29. The National Service Frameworks

The National Service Frameworks (NSF) are a collection of strategies to address the prevention and treatment of cancer, coronary heart disease, COPD, diabetes, kidney care, long-term conditions, mental health issues and stroke. The frameworks also address caring for the elderly and providing end-of-life care. Each framework includes a supporting document detailing evidence, strategies, and performance targets aimed at driving up standards and cutting variations in services. Public reports detail the progress made in each area and how the frameworks have been adapted in response to outcomes.

Stakeholders include all health providers, practitioners, and partners who work with the National Health Service (NHS), a government-run health care system in the United Kingdom. NHS directives are implemented on a mass scale in an integrated system that spans social service sectors and community institutions. As such, scalability of the National Service Frameworks in the United States is impeded by the structural differences between the two healthcare systems.

The online database for the National Service Frameworks includes links to additional resources, such as relevant sectors and services within the NHS as well as external organizations. Educational material is provided for patients and caregivers on each of the topics. The frameworks are in a state of ongoing development and at various levels of implementation. Specific domains and measures are provided for each framework and used system-wide.

http://www.nhs.uk/nhsengland/nsf/Pages/Nationalserviceframeworks.aspx

30. National Strategy for Quality Improvement in Health Care

This initiative aims to create national priorities for improving the quality of healthcare in the U.S. by aligning public and private interests. The National Quality Strategy (NQS) is part of the Affordable Care Act and identifies three aims: better care; more affordable care; and healthy people/health communities. The NQS supports proven interventions that address the behavioral, social, and environmental determinants of health. Strategies are outlined to achieve the NQS aims, and a set of 10 principles are defined to govern how healthcare services should be provided and how institutions and health professionals should conduct their activities. The six National Quality Strategy priorities can also be considered domains for measurement.

The framework stresses the need for multistakeholder involvement across a spectrum that includes individuals, family members, payers, providers, employers, and communities. Tools include a stakeholder toolkit comprising factsheets and educational materials. The 2013 report relays mixed results with some progress toward aspirational targets. The National Quality Strategy is intended to be scalable and has already implemented broadly.

http://www.ahrq.gov/workingforquality/

31. Operation Live Well

Operation Live Well is the health and wellness initiative of the Department of Defense. The initiative references a variety of other sources that use evidence-based practices, such as the CDC Office on Smoking and Health, and establishes a set of tools and resources for members of the military and their families. Operation Live Well is designed to be scaled across the military community and provide an online resource for topics such as mental wellness, integrative wellness, sleep, physical activity, nutrition, and tobacco-free living. Stakeholders include various factions of the military as well as military healthcare providers. The initiative defines key terms such as "lifespace," which is described as the area where behaviors and choices impact lives and our health. These decisions form a "performance triad" made up of three key components of health: sleep, activity, and nutrition.

http://www.militaryonesource.mil/olw

32. Pioneering Healthier Communities

Pioneering Healthier Communities is an initiative that focuses on policy and environmental change in communities to support healthy lifestyles. A set of "Leading Practices" has emerged as a conceptual model, and supportive tools for assessing and measuring population health are provided. The initiative is a partnership with CDC and based on proven strategies, while the "Lessons and Leading Practices" model is based on the field results of the program. Programs are already being implemented in various communities nationwide through YMCA facilities, with continued refinement as the framework is honed.

Diversity of stakeholders is a key element of the initiative and framework, and guidance on partnerships is detailed in a section of the "Lessons and Leading Practices" report focused on forming effective teams.

The Community Health Living Index (CHLI) provides assessments for six key community settings: after school child care sites, early childhood programs, neighborhoods, schools, work sites, and the community at large. Each assessment contains questions about policies and practices that support healthy lifestyles; each question provides a "best practice" or improvement idea for sites to implement.

Initiative materials include "Signs of Success," detailing program achievements and progress toward goals, and are presented in plain language and an accessible format with the intention of being used as a community resource and tool.

http://www.ymca.net/sites/default/files/pdf/phc-lessons-leading-practices.pdf

33. Practical Playbook

The Practical Playbook is a resource for public health and primary care groups looking to work together to improve population health. The web-based, interactive tool guides users through a scalable framework detailing the stages of integrated population health improvement. The Playbook also provides a localized database of external resources and information that can assist with integration efforts and is in the process of developing a social networking platform for public health and primary care groups seeking or working on integrated projects.

Various stakeholders are specified in the framework as suggested collaborators and/or project initiators, including social services departments and other agencies, such as substance abuse or mental health

organizations, nonprofit organizations, members of the business community such as the Chamber of Commerce and faith-based communities. The Playbook also provides a tool to identify potential partners.

The website presents “success stories” of projects and initiatives that have used the integrated model to approach population health improvement, and the project includes a guide about using “common language.” The framework does not include information on specific domains or measures, but refers users to the Health Indicator Warehouse. Information about the development of the framework itself and any supporting evidence is not provided.

http://playbook.smashingboxes.info/integration/stages-integration

34. Primary Care and Public Health: Exploring Integration to Improve Population Health

The Institute of Medicine identifies a set of core principles derived from successful integration efforts that involve the community in defining and addressing needs for population health improvement. The framework emphasizes that the collection and use of data to assess needs and progress is important to the integration process, and that sharing data appears to be a natural way in which primary care and public health can work together. The report uses cases studies and examples to support its recommendations, as well as an extensive literature review and an assessment of local programs.

The report determines that it is not possible to prescribe a specific model or template for how integration between primary care and public health should look. Instead, it identifies a set of five core principles derived from successful integration efforts. Specific recommendations are included for The Centers for Disease Control and Prevention, The Human Resources and Services Administration, and the Department of Health and Human Services to create an environment that would foster broader integration of primary care and public health. The principles are useful for state and local entities to consider, but the report states that scalability is a challenge at the local level since communities are rarely able to move beyond their initial start-up site. Sustainability also continues to challenge local partners and has limited the impact of successful primary care and public health integration efforts in the past. However, the report emphasizes that many opportunities exist to promote better integration, and more have been created due to the Affordable Care Act.

Integration can start with any of the following five core principles outlined in the report:

- A common goal of improving population health;
- Involving the community in defining and addressing its needs;
- Strong leadership that works to bridge disciplines, programs, and jurisdictions;
- Sustainability; and
- The collaborative use of data and analysis.

The key stakeholders addressed are public health entities and primary care providers, while other community stakeholders are involved in the process to assess needs and mutually determine priorities. The report addresses the cultural barriers between primary care and public health and includes 10 pages of definitions for “primary care,” “public health,” and “integration.”

http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx

35. Project Healthy Grad

This program aims to improve the health of college students through increasing access to healthcare, promoting healthy lifestyle choices, promoting a tuition assistance program, and advocating policy changes that support healthy students. The project is based on the research and guidelines of the County Health Rankings & Roadmaps program through the Robert Wood Johnson Foundation, which is used for both community needs assessment and development of an evidence-based framework.

The umbrella program of Project Healthy Grad, 1 in 21 Muskegon County, has created guides for healthy living accessible on the website, including “The ABCs of Good Health” and “Staying Sane in a Whirlwind World.” The website also lists external educational and informational resources.

The project is founded on the idea that people with more education are more likely to experience better health outcomes for themselves and their families, and that academic success and health are linked. Partners include local multistakeholder alliances, schools, nonprofit organizations and the local public health department. No domains or measures are identified. The project’s goals are to increase access to healthcare for students and their families; promote healthy lifestyle choices to improve the health of the community; boost enrollment in the state-funded Tuition Incentive Program to get more students moving into higher education opportunities; and advocate policy changes to support healthy, successful students. No information on the status or progress of the project’s strategies and goals is provided.

http://1in21.org/phg

36. Regional Equity Atlas 2.0 and Action Agenda

This population health improvement tool maps the intersection of chronic disease prevalence data and data on the social, economic, and physical determinants of health for the Portland metro region, providing insight into key findings. Various data sources are used, including public health data and surveys, as well as administrative data from health plan providers. Domains are identified and measures suggested in the data sources chosen.

In addition to creating access to diverse data sources for population health insight, the project also allows unique map creation using that third-party data. The project lists “Atlas in Action” stories, suggesting that the tool has been used by various entities and organizations for planning, analysis, and assessment purposes as part of population health improvement projects.

http://clfuture.org/equity-atlas

37. State Innovation Models Initiative

The State Innovation Models Initiative is providing up to $300 million to support the development and testing of state-based models for multipayer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states. Projects are intended to be broad based and focus on people enrolled in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP). So far, 6 states have received grants and 16 others have received planning grants.

The Centers for Medicare & Medicaid Services Innovation Center created the State Innovation Models initiative for states preparing or committed to planning, designing, testing, and supporting evaluation of

the new payment and service delivery models in hopes of lowering costs while maintaining or improving quality of care for program beneficiaries. An overarching goal is to create models that can raise community health status and reduce long term health risks for beneficiaries.

http://innovation.cms.gov/initiatives/state-innovations/

38. Toward Quality Measures for Population Health and Leading Health Indicators

These recommendations from the Institute of Medicine provide a framework to inform and support the development, endorsement, promotion, and use of a unified and coherent set of quality measures across a range of settings in population health assessment, improvement, and accountability. Developers used the Donabedian framework for measurement to identify a defined set of recommended quality measures, with a focus on health outcomes. This logic model supposes that resources and capacity, plus research, lead to interventions and subsequent health outcomes. The report builds on the National Quality Strategy and Healthy People 2020 and recommends approaches to develop and refine these measures to create a parsimonious set for population health measurement.

Measurement domains include the 26 leading health indicators outlined in Healthy People 2020 as well as 12 additional topics: access to health services; clinical preventive services; environmental quality; injury and violence; maternal, infant, and child health; mental health; nutrition, physical activity, and obesity; oral health; reproductive and sexual health; social determinants; substance abuse; and tobacco.

The recommendations are aimed at creating a coherent and cohesive system of measurement, designed to be led by the Department of Health of Human Services with cooperation from stakeholders. Therefore, the framework is not intended to be scalable in terms of duplication, but in terms of broad buy-in to a single effort. The report specifies that measurement must be inclusive and workable at the local, state, and national level, involving the spectrum of stakeholders in each.

http://www.iom.edu/Reports/2013/Toward-Quality-Measures-for-Population-Health-and-the-Leading-Health-Indicators.aspx

39. Vermont Blueprint for Health

The Vermont Blueprint for Health is a state-led initiative aimed at transforming the way that health care and overall health services are delivered in Vermont by providing the community with a continuum of seamless, effective, and preventive health services, while reducing medical costs. The initiative aims to create a replicable model and provides an "implementation manual" intended for a broad range of stakeholders — including primary care practices, health centers, hospitals, and providers of health services (medical and nonmedical) — to implement the Blueprint's Multi-payer Advanced Primary Care Practice (MAPCP) model in their community become part of a statewide Learning Health System.

Various research and reports are cited as the basis for the framework, including "Core Principles & Values of Effective, Team-Based Health Care" from the Institute of Medicine. Annual reports describe the cumulative growth trends of the number of participating and recognized primary care practices, the character and reach of the Community Health Teams, and the implementation of Support and Services at Home (SASH) for elderly and disabled Medicare beneficiaries, as well as progress on specific goals.

Community tools offered through the initiative include healthier living workshops and tobacco cessation workshops, in addition to supporting educational materials. The initiative focuses on self-management and the utilization of community health workers as a way to increase individual responsibility for health and lighten the burden on healthcare providers.

http://hcr.vermont.gov/blueprint

40. White Earth Nation Tobacco Coalition

This action plan to reduce commercial tobacco use in the tribal community of White Earth is an AF4Q project based on the research and guidelines of the County Health Rankings & Roadmaps program through the Robert Wood Johnson Foundation. The project aims to create educational materials and policy guides for individuals, healthcare providers, and community institutions to promote tobacco cessation and protection from secondhand smoke. The initiative reports achieving its objectives, which are predominantly the production of educational materials and conglomeration of current policies relating to tobacco use.

A key part of the project is addressing culturally specific elements of the issue. Educational materials provide culturally specific terminology and context, such as an explanation of “sacred tobacco” or “Asayma” and a language style that is unique to tribal belief systems. For example, the community is referred to as “the people” and educational materials stress that sacred tobacco should only be used the way it was intended, in prayer and offering in the morning and “never inhaled.”

Since the project is dealing with a health topic in a culturally specific way, the specifics may not be scalable to nontribal communities. However, the awareness and integration of culture into policy guidelines and educational materials could be the scalable element.

http://www.whiteearth.com/programs/?page_id=405&program_id=4#Tobacco

Appendix E
Project Staff

National Quality Forum Staff

Karen Adams, PhD, MT
Vice President, Strategic Partnerships

Nadine Allen
Project Analyst, Strategic Partnerships

Adeela Khan, MPH
Project Manager, Performance Measurement

Allen Leavens, MD, MPH
Senior Director, Strategic Partnerships

Elisa Munthali, MPH
Managing Director, Performance Measurement

Danitza Valdivia
Administrative Manager, Strategic Partnerships

Consultant

Diane Stollenwerk, MPP
President, StollenWerks Inc.

National Quality Forum
1030 15th St NW, Suite 800
Washington, DC 20005
http://www.qualityforum.org