# Multi-stakeholder Input on a National Priority: Improving Population Health by Working with Communities

NATIONAL QUALITY FORUM

In-Person Meeting Materials

**January 9-10, 2014**

NATIONAL QUALITY FORUM

# Agenda

## Multi-stakeholder Input on a National Priority: Improving Population Health by Working with Communities

## Committee In-person Meeting

## January 9-10, 2014

**Instructions for Remote Participation:**

**Streaming Audio Online**

- Direct your web browser to http://nqf.commpartners.com/se/NQFLogin/
- Under "Enter Meeting" type the meeting number **138059** (**Day 1**)**/442178** (**Day 2**) and click "Enter."
- In the "Display Name" field type your first and last names and click "Enter Meeting."

**Teleconference**

**Committee Member/Speakers**

- Dial **1-888-802-7237** and use confirmation code **15432178** (**Day 1**)**/15436812** (**Day 2**).

**Public Participants**

- Dial **1-877-303-9138** and use confirmation code **15432178** (**Day 1**)**/15436812** (**Day 2**).

## Meeting Objectives:

- Establish consensus and commitment on the project scope and goals;
- Discuss key findings from the analysis of frameworks and develop recommendations for the Community Action Guide; and
- Operationalize next steps and identify areas for the Committee to directly engage in the further development of the Community Action Guide.

**Day One**

**8:30 am** **Breakfast**

**9:00 am** **Welcome and Introductions**
*Bruce Siegel, MD, MPH (Co-Chair)*
*Kaye Bender, PhD, RN, FAAN (Co-Chair)*
*Karen Adams, PhD, Vice President, Strategic Partnerships*

**9:15 am** **Disclosure of Conflict of interest**
*Ann Hammersmith, General Counsel*

**9:45 am** **Opening Remarks**
*Christine Cassel, MD, President and CEO, NQF*
*Nancy Wilson, MD, Government Task Lead, AHRQ*

**10:00 am** **Stage Setting and Committee's Charge**

- Project Overview
- Community Action Guide: audience, purpose and scope

*Elisa Munthali, MPH, Managing Director, Performance Measurement, NQF*

**10:45 am** **Population Health across NQF Programmatic Areas**

*Allen Leavens, MD, Senior Director, Strategic Partnerships, NQF*

**11:00 am** **Framework Analysis: Overview and Key Themes**

- Approach to the environmental scan and analysis
- Definitions
- Key findings and cross case insights

*Diane Stollenwerk, MPP, Consultant, StollenWerks Inc.*

**11:45 pm** **Public Comment**

**12:00 pm** **Lunch**

**12:45 pm** **Building the Community Action Guide**

- Discussion: Multi-level engagement at the community/local, state and federal levels

*Paul E. Jarris, MD, MBA (reactant)*

*<u>Discussion Question:</u>*
*What principles should be applied to ensure that the structure and content of the Community Action Guide support multi-level engagement?*

**1:45 pm** **Building the Community Action Guide**

- Discussion: Public-private partnerships

*Reneé Frazier, MHSA, FACHE (reactant)*
*Federal Liaison*

*<u>Discussion Questions:</u>*
*Given likely variation from community to community, are there certain stakeholder types who should be noted as higher priority? If so, which?*

*What principles should the Action Guide include to support appropriate attention to addressing cultural issues, both within and across stakeholder types?*

**2:45 pm** **Public Comment**

**3:00 pm** **Break**

**3:15 pm** **Building the Community Action Guide**

- Discussion: Community Health Needs Assessment (CHNA)
  - Identifying priority health needs
  - Addressing disparities in care

*Charles J. Homer, MD, MPH (reactant)*
*Julie Trocchio, RN, MS (reactant)*

*Discussion Question:*
*How should the Community Action Guide balance the need for communities to conduct their own CHNA to identify priorities and the value of encouraging aligned focus on high priority improvement topics, including addressing disparities?*

**4:15 pm** **Public Comment**

**4:30 pm** **Next steps for Day 2**

**5:00 pm** **Adjourn**

**Day Two**

**8:00 am** **Breakfast**

**8:30 am** **Welcome and Day One Recap**
*Bruce Siegel, MD, MPH (Co-Chair)*
*Kaye Bender, PhD, RN, FAAN (Co-Chair)*

**8:45 am** **Building the Community Action Guide**

- Discussion: Data (cycle time, granularity & frequency) measures, and tools

*Christina Bethell, PhD, MBA, MPH (reactant)*
*Shelley B. Hirshberg, MA (reactant)*
*Federal liaison*

*Discussion Question:*
*What are the common implementation challenges that communities experience in population health improvement and what types of resources are most helpful (data sources, tools to support specific health improvement activities, measures)?*

**10:00am** **Public Comment**

**10:30 am** **Break**

**10:45 am** **Building the Community Action Guide**

- Discussion: Measuring success and evaluating impact

*Bruce Siegel, MD, MPH (reactant)*
*Matthew Stiefel, MS, MPA (reactant)*

*Discussion Question:*
*What are the steps that can create a practical path to enable and encourage program evaluation?*

*Should the Action Guide encourage transparency with the entire community around the results of the initiative?*

**12:00 pm** **Public Comment**

**12:30pm** **Lunch**

**1:30pm** **Building the Community Action Guide**

- Discussion: Sustainability and scalability
    - Defining parameters and public policy opportunities

*Debra L. Burns, MA (reactant)*

*Discussion Questions:*
*What are the principles that should be used in the Action Guide to help define sustainability and scalability?*

*Which public policy issues are important to highlight as opportunities for sustainable approaches to population health improvement?*

**2:30pm** **Next Steps: Ongoing Committee Engagement in Developing the Community Action Guide**
*Bruce Siegel, MD, MPH (Co-Chair)*
*Kaye Bender, PhD, RN, FAAN (Co-Chair)*

**3:00 pm** **Adjourn**

# Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities

NATIONAL QUALITY FORUM

In Person Meeting
January 9-10, 2014

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## Welcome & Introductions
## Overview of Meeting Objectives

Bruce Siegel, MD, MPH (Co-Chair)
Kaye Bender, PhD, RN, FAAN (Co-Chair)

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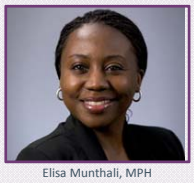
## Meeting Objectives

- Establish consensus and commitment on the project scope and goals;
- Discuss key findings from the analysis of frameworks and develop recommendations for inclusion in the Community Action Guide; and
- Operationalize next steps and identify areas for the Committee to directly engage in the further development of the Community Action Guide.

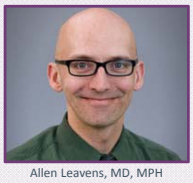


## Lead Project Staff

Karen Adams, PhD, MT
Vice President, Strategic Partnerships

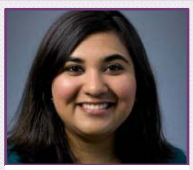


Elisa Munthali, MPH
Managing Director, Performance Measurement



Allen Leavens, MD, MPH
Senior Director, Strategic Partnerships

Diane Stollenwerk, MPP
Consultant



Adeela Khan, MPH
Project Manager, Performance Measurement

Zehra Shahab, MPH
Project Analyst, Performance Measurement

Danitza Valdivia
Administrative Manager, Strategic Partnerships

## Disclosure of Conflict of Interest

Ann Hammersmith, General Counsel



## Opening Remarks

Christine Cassel, MD, President & CEO, NQF

Nancy Wilson, MD, Government Task Lead, AHRQ

# Stage Setting & Committee's Charge

Elisa Munthali, MPH, Managing Director,
Performance Measurement, NQF



## National Quality Strategy

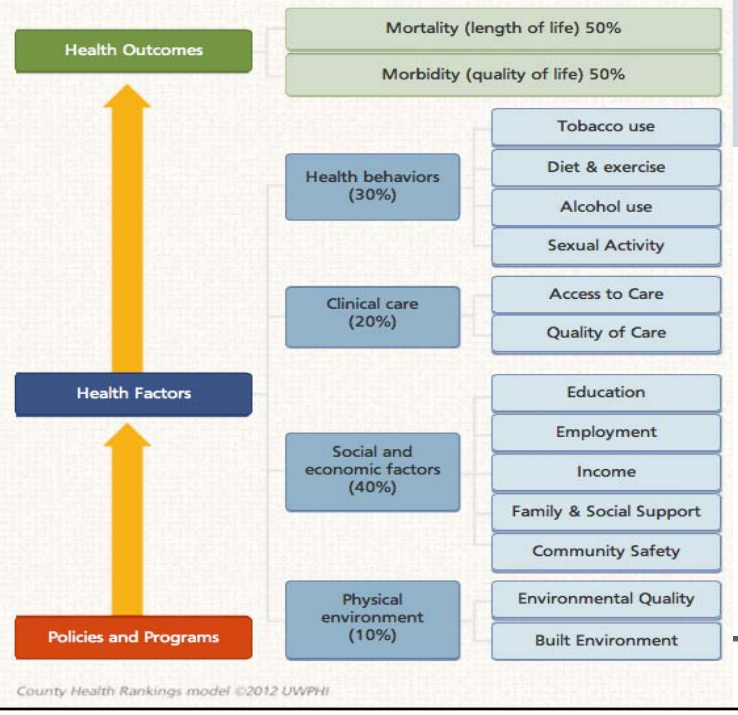
## National Quality Strategy Goals—Long-Term Goals for Working with Communities

1. Promote healthy living and well-being through community interventions that result in improvement of social, economic, and environmental factors.
2. Promote healthy living and well-being through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan.
3. Promote healthy living and well-being through receipt of effective clinical preventive services across the lifespan in clinical and community settings.

| MEASURE FOCUS | KEY MEASURE NAME/DESCRIPTION | CURRENT RATE |
|---|---|---|
| Depression | Percentage of adults reported symptoms of a major depressive episode (MDE) in the last 12 months who received treatment for depression in the last 12 months | 68.3%* |
| Obesity | Proportion of adults who are obese | 35.7%** |

*Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, National Survey on Drug Use and Health, 2010.
** Source: Centers for Disease Control and Prevention, National Health and Nutrition Examination Survey (NHANES), 2010.





## Setting the Context: Audience, Purpose & Scope

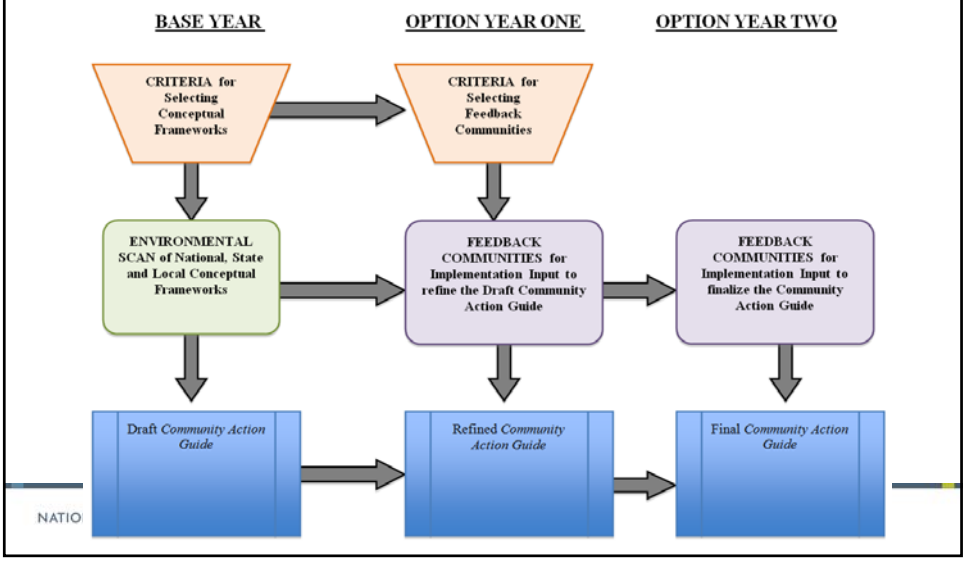
- **Communities, public health-** and **clinical care systems** need to work collaboratively to improve population health.
- **Shared definitions** and a **common conceptual framework** are needed to ensure better coordination and advance community partnerships.
- **Multistakeholder process** to develop a common framework for communities that will offer **practical guidance to improve population health**.



## Base Year Timeline

| Step 1: Project initiation and outreach to stakeholder groups (Month 1) | Step 2: Conduct Environmental Scan and analysis and convene multistakeholder groups (Months 1-3) | Step 3: Draft Community Action Guide (Months 4-7) | Step 4: Finalize Community Action Guide (Months 7-11) |
|---|---|---|---|
| Conduct in-person kick-off meeting with DHHS | Determine scope of environmental scan and analytic approach | Convene in-person Committee meeting #1 | Hold public webinar |
| Appoint Advisory Group | Conduct Advisory Group web-meeting | Incorporate Committee feedback and revisions | Convene in-person Committee meeting #2 |
| Open call for Committee nominations | Conduct environmental scan and analysis | Convene Committee web meeting | Revise draft Action Guide with committee and public feedback |
| Finalize Committee | *Deliverable*: Written Scan & Analysis | *Deliverable*: Draft Community Action Guide | *Deliverable:* Final Community Action Guide |

## Starting with the End in Mind: Connections across Project Deliverables




## Key Questions that the Final Community Action Guide will Address

### Final Community Action Guide

- How can individuals and multistakeholder groups come together to address community health improvement?
- Which individuals and organizations should be at the table?
- What processes and methods should communities use to assess their health?
- What data are available to assess, analyze, and address community health needs, and measure improvement?
- What incentives exist that can drive alignment and coordination to improve efficiency and community health?
- How should communities assess if their initiative is achieving results and ensure a feedback loop is in place for shared learning?

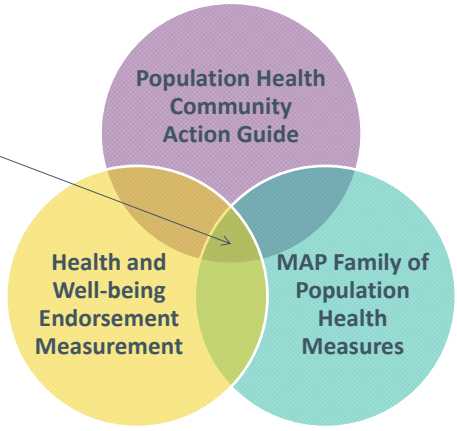
# Population Health across NQF Programmatic Areas

Allen Leavens, MD, Senior Director, Strategic Partnerships, NQF



## NQF's Current Work on Population Health

- Aligned with NQS' Three-Part Aim
- Focus beyond medical model – increased emphasis on determinants of health and improvement activities
- Address measurement, measure gaps, methodological and other challenges of population health measure development
- Opportunity to leverage population health activities and to exchange ideas between committees



## Consensus Development Project: Population Health Phase I and II 2012

**Project Summary**

- NQF commissioned a white paper that presented an environmental scan of existing measures and guidance for assessing and measuring population health, determinants of health and improvement activities.
- The Steering Committee developed additional guidance and context for measures addressing population health issues.
- Phase I endorsed 19 measures addressing influenza and pneumococcal immunizations across many healthcare settings, as well as screenings for specific cancers, sexually transmitted infections, and osteoporosis.
- Phase II endorsed 5 healthy lifestyle behavior and broader population-level measures, including those that can assess social, economic, and environmental determinants of health and outcomes.



## Consensus Development Project: Health and Well Being 2014

**Project Summary**

NQF will review endorsed maintenance measures that address population health and seeks to identify and endorse new measures that can be used to assess health and well-being across all levels of analysis, including healthcare providers and communities. Specifically:

- measures that assess health-related behaviors (e.g. smoking, diet) and practices to promote healthy living
- community-level indicators of health and disease (e.g. disease incidence and prevalence) and community interventions (e.g. mass screening)
- primary prevention and screening (e.g. influenza immunization)
- modifiable social, economic, environmental determinants of health with demonstrable relationship to population health outcomes

## Measure Applications Partnership

**Statutory Authority**

Health reform legislation, the Affordable Care Act (ACA), requires HHS to contract with the consensus-based entity (i.e., NQF) to **"convene multi-stakeholder groups to provide input on the selection of quality measures" for public reporting, payment, and other programs.**



## MAP Purpose

**In pursuit of the NQS, MAP informs the selection of performance measures to achieve the goal of improvement, transparency, and value for all**

- MAP Objectives:
  1. Improve outcomes in high-leverage areas for patients and their families
  2. Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy on value
  3. Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden

## Families of Measures and Core Measure Sets

**Families of Measures**

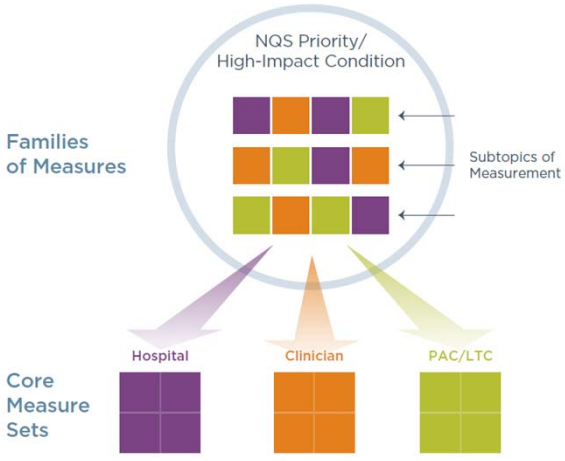
"Related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS " (e.g., care coordination family of measures, diabetes care family of measures)

**Core Measure Sets**

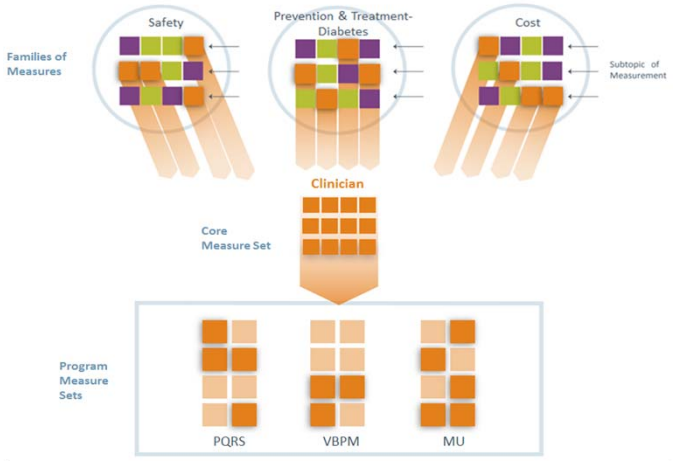
"Available measures and gaps drawn from families of measures that should be applied to specified programs, care settings, levels of analysis, and populations" (e.g., ambulatory clinician measure set, hospital core measure set, dual eligible beneficiaries core measure set)



## Families of Measures



## Families of Measures Populating Core Sets and Program Sets






# Analysis of Frameworks: Overview & Key Themes

Diane Stollenwerk, MPP, Consultant, StollenWerks Inc.

## Environmental Scan: Audience, Purpose & Scope

**Audience**

- The Committee and key partners working on the *Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities* project

**Purpose**

- Inform the creation of a *Guide for Community Action (Action Guide),* a resource for local, state, regional groups to improve population health

**Scope**

- Identifies key elements of national, state and local frameworks and initiatives for creating an evidence-based framework for improving population health, along with related measures, data sources, tools, and other resources



## Environmental Scan: Approach

- Designed with the end in mind: informing development of the *Action Guide*
  - Conceptual frameworks and implementation resources
  - Deliberately diverse mix of frameworks and initiatives
- Definitions
  - ✓ Community
  - ✓ Community Action Guide
  - ✓ Data Sources
  - ✓ Framework
  - ✓ Health
  - ✓ Measures
  - ✓ Population Health
  - ✓ Tools

## Environmental Scan: Key Definitions

A **Community** is a group of people who have common characteristics; communities can be defined by geographic proximity, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other similar common bonds.

(*Turnock, BJ. Public Health: What It Is and How It Works. Jones and Bartlett, 2009.)*

A **Population** may be determined based on all individuals within a geopolitical area, but other characterizations exist

- Focus on **Health** should be from a broader perspective of well-being rather than the mere absence of disease
- Requires involvement of the public health system, the clinical care system, and other diverse stakeholders

*(Jacobson and Teutsch, 2012)*



## Environmental Scan: Selection Criteria for the Mix

- Greatest potential impact: addressing high impact needs, topics or conditions
- Across the lifespan: affecting individuals at various stages, birth to end of life
- Geographic diversity: urban / rural, region of the USA
- Disparities & socioeconomic status

## Environmental Scan: Examining Frameworks and Initiatives

**Federal/National**

- Department of Health & Human Services
- Department of Defense
- Other federal liaisons (e.g. Departments of Agriculture, Education, HUD, Justice, Labor, and Transportation; VA; EPA; OPM)
- Institute of Medicine reports
- National Quality Forum reports

**State and Regional or Community**

- References within frameworks or white papers, or mentioned by key stakeholders as outstanding examples
- National programs that drive state action
- National programs that drive local action
- Foundation-funded population health projects

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## Environmental Scan: Identifying Frameworks and Initiatives

Key informant strategy, face validity with experts from HHS and the Advisory Group, then rated using initial criteria and descriptions

Assessment and Analyisis of 40 Frameworks and Initiatives in the Enviromental Scan

Individually Scored 72 Frameworks and Initiatives Against the Nine Criteria

Narrowed to 72 Frameworks based on Expert Guidance and Emphasis on Programs Supported by a National Structure

700+ National, State and Local Frameworks and Initiatives Initially Identified

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## Environmental Scan: Practical Challenges

**Variation!**

- Mix of conceptual frameworks, programs and implementation resources
- Levels of experience for those involved in population health improvement: some have long history, some are new
- Cultures vary across organizations, sectors and communities
- Many organizations, sectors and communities have traditionally approached their important work in silos



## Environmental Scan: Foundational Assumptions

- To reflect the mix… To address the range of experience… To bridge the cultures… To break down the silos…
  - A balance between broad and specific approaches is needed
  - Health is a holistic concept, not narrow in focus or scope
  - Equity must be front and center, with a focus on eliminating disparities
  - Sustainability and scalability must be addressed in some way
- An iterative approach to the project must be taken, with new insights expected along the way

## Environmental Scan: Overall Themes

**Several frameworks address all of the criteria elements**

These elements appear to be the right starting place

1. An organizational planning and priority-setting process
2. A community health needs assessment process
3. An agreed-upon, prioritized subset of health improvement activities
4. Takes responsibility for leading a health improvement activity
5. Selection of measures or indicators and performance targets
6. Use of those same prioritized indicators
7. Joint reporting on progress toward achieving the intended results
8. A plan for sustainability
9. Indications of scalability



## Environmental Scan: Overall Themes (cont.)

**But none include all of the key implementation resources**

Conceptual framework to guide community engagement to improve population health (*see criteria on previous slide*)

- Conceptual framework to guide activities that address a specific health need
- Data source(s)
- Population health improvement program being implemented
- Measure domains or measures
- Tool(s)

## Environmental Scan: Overall Themes (cont.)

**Multi-level engagement is important**

- This recognizes the multi-faceted and interrelated nature of population health improvement
- Nearly all of the frameworks and initiatives involve or recognize the importance of aligned action at two or more levels
  - Local
  - State
  - National



## Environmental Scan: Overall Themes (cont.)

**Priority topics for population health improvement are wide ranging**

- 30 addressed health generally and 11 addressed disparities
- Each of these topics were addressed by five or more frameworks
  - Behavioral health
  - Obesity
  - Tobacco
  - Cardiovascular health
  - Diabetes
  - Education
  - Health information management or exchange
  - Maternal and infant health

## Environmental Scan: Overall Themes (cont.)

**A majority address social, environmental and behavioral determinants, and nearly all address behavioral determinants**

- *Behavioral* examples: promoting physical activity; education about portion size and nutrition; reducing tobacco use – in workplaces, primary care clinics, wellness centers on military bases, classrooms, jails
- *Environmental* examples: elevating public health functions; physical proximity to better food choices; redesigned surroundings to encourage physical activity; smoke-free environments – in the workplace, military bases, schools, parks, museums, gardens, communities at large
- *Social* examples: improving educational attainment; securing government benefits and tuition assistance; building career skills; creating stronger personal and spiritual connections – with emphasis on changing social mores and public policy to break down barriers



## Environmental Scan: Overall Themes (cont.)

**Planning appears to be more common than measuring success against goals**

- Information was drawn from publicly-available sources, perhaps measurement results are available yet private?
- About half describe objectives or goals
- Most information about performance against objectives or goals is expressed as stories rather than measured results

## Environmental Scan: Overall Themes (cont.)

**The abundance of measure domains, measures, and data sources may be counter-productive**

- Raises the question of focus: do too many options create white noise and obscure what is actually available?
- Raises questions about which are the most action-oriented:
  - » Which are easy to use?
  - » Which have the appropriate level of granularity
  - » Which are available at a frequency that is relevant?
  - » Which are updated in cycles that ensure useful feedback?



## Environmental Scan: Overall Themes (cont.)

**The format of tools helps to ensure their usefulness**

- A wide variety of tools, such as checklists, interactive maps, customizable guides, pamphlets and educational materials
  - Nearly all are available through websites designed for use by key stakeholders, including the public
  - Strong emphasis on plain language and accessibility
- In addition to informing the content, raises questions regarding the most effective format for the Action Guide itself

## Environmental Scan: Cross Case Insights to Explore

**Divergence in criteria may signal gaps to address in the conceptual framework included in the Action Guide**

- Examples include:
  - Attend to effective communication
  - Plan to be adaptable
  - Deliberately engage individuals and families
  - Take action to change policy
  - Others to consider: workforce needs, information technology and exchange, equity and cultural barriers, reward and recognition



## Environmental Scan: Cross Case Insights to Explore (cont.)

**Sustainability and scalability need further definition**

- Such assessments require detail often unavailable publicly
- Thresholds to assess these two concepts were not established
- These concepts may not apply to framework or initiative
- Taking an inclusive approach, if a framework or initiative recommends or mentions:
  - A sustainability or business plan, and/or is funded by a multiyear grant or government source, it counted as sustainable
  - That it was designed to be scalable or describes how it can be replicated by others, it counted as scalable

## Environmental Scan: Cross Case Insights to Explore (cont.)

**New infrastructures and public policy create opportunity**

- Many note that structural change increases sustainability
  - Examples: policy commitments, new patterns of care and coordination among stakeholders, linking medical and public health information systems
- Many capitalize on new opportunities in the current market
  - Examples: ACOs, Accountable Health Communities, Patient Centered Medical Homes, community health improvement requirements for nonprofit hospitals, Public Health Accreditation
- Several call out gaps to be addressed via changes in public policy



## Environmental Scan: Cross Case Insights to Explore (cont.)

**Use of culturally appropriate, plain language is important**

- Several provide lists of definitions of terms, explain acronyms, and/or call out the importance of using understandable words
- Some offer frameworks and toolkits to support plain language and effective communication
- Several include guidance on how to connect topics with cultural beliefs as a way to create compelling messages
  - » Cross-cultural examples include ethnic groups and organizations or sectors

## Environmental Scan: Cross Case Insights to Explore (cont.)

**Stakeholder involvement varies, with some notable gaps**

- Many name the importance of effective communication and public education, but only one names "the media" as a stakeholder
- Given the range of population health improvement topics plagued by disparities, minorities or specific ethnic groups as key stakeholders may be underrepresented



## Environmental Scan: Nine Discussion Points

1. Refining the conceptual framework to guide community engagement to improve population health, which additional criteria should be added, if any?
2. Should the Action Guide include a framework for addressing a specific priority health improvement topic?
   - How will the top priority be selected?
   - Are there threshold criteria that should apply to make this decision (e.g., not a health condition, universally important, high impact)?

## Environmental Scan: Nine Discussion Points (cont.)

3. Because the Action Guide is intended to be useful for implementation, what approach should shape its content?
   - Offer content that supports the conceptual *engagement* framework with no assumed priority topic(s)
   - Offer a conceptual engagement framework, plus a framework for *one priority topic* about which the Action Guide would include measures, data sources, and tools
   - Offer a conceptual engagement framework, plus one or two priority topics about which the Action Guide would include measures, data sources. and tools
   - Other



## Environmental Scan: Nine Discussion Points (cont.)

4. Many initiatives and frameworks contain useful tools, but few cite evidence or research as the basis for the tools; must these resources be "evidence-based" to be included in the Action Guide?

5. Should the Action Guide reference any measures, data sources, or tools that are only available to people for a fee (e.g., dues paying members or customers)?

## Environmental Scan: Nine Discussion Points (cont.)

6. How should sustainability and scalability be defined and applied when determining content for the Action Guide?
   - Is "scalability" relevant to every conceptual framework, program insight, measure set, data source, or tool? What parameters determine whether each relevant element is scalable?
   - Is "sustainability" relevant to every conceptual framework, program insight, measure set, data source, or tool? What parameters can be used to determine whether each relevant element is sustainable?



## Environmental Scan: Nine Discussion Points (cont.)

7. What terms should be defined in the Action Guide?
8. Should the Action Guide be developed with a dynamic format versus a static format (e.g., print or PDF report only)?
9. Given the chosen approach to the Action Guide content and format, what are the implications for Feedback Communities?
   - What is the role and expected engagement level from the Feedback Communities?
   - What questions will be posed to Feedback Communities to test the Action Guide and inform its refinement?
   - Based on these expectations, what criteria should be used to select Feedback Communities?

# Building the Community Action Guide



## Building the Community Action Guide: Multi-level Engagement at Community, State & Federal Levels

- *What principles should be applied to ensure that the structure and content of the Community Action Guide support multi-level engagement?*

## Building the Community Action Guide: Public-Private Partnerships

- *Given likely variation from community to community, are there certain stakeholder types who should be noted as higher priority? If so, which?*
- *What principles should the Action Guide include to support appropriate attention to addressing cultural issues, both within and across stakeholder types?*



# Community Health Needs Assessments

January 9, 2014

NQF Meeting on Population Health Improvement

Julie Trocchio
Senior Director, Community Benefit and Continuing Care
Catholic Health Association

## Community Health Needs Assessment (CHNA):

**Provisions in the ACA require a tax-exempt hospital facility to:**

- ✓ Conduct a CHNA at least every three years
- ✓ Take into account input from persons who represent the broad interests of the community
- ✓ Take into account input from persons with special knowledge of or expertise in public health
- ✓ Make the CHNA widely available to the public




## Additional Requirements Described in the IRS Proposed Rules

- ✓ Input to CHNA must include:
  - At least one state, local tribal or regional public health department
  - Members of medically underserved, low-income and minority populations or their representatives
  - Written comments on previous CHNAs

## CHNA (con't)

- ✓ Written CHNA report must include:
  - Definition of the community served
  - Description of the process and methods used to conduct the assessment, including:
    - Description of how the hospital took into account input
    - A prioritized description of significant community health needs
    - A description of the potential resources to address the significant health needs
- ✓ Assessment report must be adopted by an authorized body of the hospital




## Implementation Strategy

**Provisions in the Affordable Care Act require a tax-exempt hospital to:**

- ✓ Adopt an implementation strategy to meet community needs identified in the CHNA
- ✓ Describe how it is addressing needs identified in the CHNA
- ✓ Describe any needs identified in the CHNA that are not being addressed and the reasons for not addressing them

## Additional Requirements in IRS Proposed Rules

**For each significant need:**

- The actions the hospital facility intends to take
- The anticipated impact of these actions
- A plan to evaluate the impact
- The programs and resources the hospital plans to commit
- Any planned collaboration




## Themes in ACA and IRS Rule

- Encourages collaboration
- Encourages hospital/public health partnerships
- Setting priorities among community health needs
- Attention to disparities and vulnerable populations
- Transparency

## How Hospitals Are Implementing CHNA

- Collaborating!
- Public health partnerships
- Using public health resources (County Health Rankings, Healthy People 2020, Community Guide, Prevention Strategy, Aims for Public Health Quality, academics)
- No big surprises: access, disparities, obesity and diabetes, asthma, mental health, dental health, aging and chronic illness, stroke and heart disease
- Some attention upstream to determinants of health

 

## Designating topic(s)?

- Examples: Systems, States, Cities
- Why: Evidence-base, Collective impact
- Why not:: Buy in? Subsidiarity?
- Recommendation: Options

 

## Building the Community Action Guide: Community Health Needs Assessment (CHNA)

- *How should the Community Action Guide balance the need for communities to conduct their own CHNA to identify priorities and the value of encouraging aligned focus on high priority improvement topics, including addressing disparities?*



## Next Steps for Day 2

# Recap of Themes from Day 1



## Building the Community Action Guide: Data, Measures & Tools

- *What are the common implementation challenges that communities experience in population health improvement and what types of resources are most helpful (data sources, tools to support specific health improvement activities, measures)?*

## Building the Community Action Guide: Measuring Success & Evaluating Impact

- *What are the steps that can create a practical path to enable and encourage program evaluation?*
- *Should the Action Guide encourage transparency with the entire community around the results of the initiative?*



## Building the Community Action Guide: Sustainability & Scalability

- *What are the principles that should be used in the Action Guide to help define sustainability and scalability?*
- *Which public policy issues are important to highlight as opportunities for sustainable approaches to population health improvement?*

## Next Steps: Ongoing Committee Engagement in Developing the Community Action Guide

- Committee Web Meeting: March 5, 2014 at 12-2pm ET
- Public Web Meeting: May 1, 2014 at 12-2pm ET
- In-Person Committee Meeting: June 10-11, 2014 at NQF Offices, Washington, DC

NATIONAL QUALITY FORUM

# Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities

## *Environmental Scan and Analysis to Inform the Action Guide*

*DECEMBER 20, 2013*

*This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I task order 4.*

## Contents

## Introduction

> The greatest health challenges—for example, chronic illness, health inequities, climate change, and health care costs—are highly complex and often linked. Promoting healthy communities requires addressing the social determinants of health, such as transportation, education, access to healthy food, economic opportunities, and more.[1]

The attention of national, state, and local policy and practice across the public and private sectors is increasingly turning to the question of how to reverse trends toward worsening health outcomes and poorer community health status overall. And, as universally understood as the observation above might be, the task of improving health across communities and total populations is a daunting imperative. Fortunately, a wealth of resources is now available, from the local, state, and national level, drawing on decades of research and experience of those who have been addressing the social, environmental, and behavioral determinants of health. The difference today is a shared focus on population health driven in part by the *National Quality Strategy,* as well as increasing acceptance of the need to improve health for all using multifaceted, multilevel approaches.

This environmental scan serves as a foundation for *Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities*, sponsored by the Department of Health and Human Services (DHHS). Findings from leading edge research, combined with practical insights based on actual experiences in the field, will inform the development of a guide to support practical action that is effective in improving population health.

## Executive Summary

There are literally thousands of research-based frameworks, programs, projects, and other initiatives aimed at improving population health. As part of the project, *Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities*, this environmental scan is part of the first stage in the development of a *Guide for Community Action* (*Action Guide*), a resource for groups at any level (local, state, regional) who are interested in working together to improve population health.

Using an iterative, multi-level approach designed to identify and select a diverse mix of approaches and initiatives, this report includes an assessment of forty population health frameworks, both individually and collectively. Core criteria used in selection and evaluation of the frameworks were largely drawn from previous work completed through the National Quality Forum, then refined based on guidance from a multistakeholder Committee and federal partners.

Nine criteria were used to assess individual frameworks:  the presence of an organizational planning and priority-setting process; a health and needs assessment process; an agreed-upon, prioritized subset of health improvement activities; taking responsibility for leading a health improvement activity; selection of a set of measures or indicators and performance targets; use of those same prioritized indicators; joint reporting on progress toward achieving the intended results; a plan for sustainability; and indications of scalability.

With direction from the experts involved with this project, and by applying the nine key criteria along with a purposeful attempt to ensure diversity in the overall mix of frameworks, the hundreds of initial

candidates identified for potential analysis were narrowed to the 40 that are included in this environmental scan. This report reviews the key elements of these national, state, and local frameworks and initiatives to identify central lessons and essential components for the development of an evidence-based organizing framework for improving population health. The analysis also considers practical and vitally important related elements, including measure domains, measures, data sources, and tools to support the needs of program implementers.

Based on the multifaceted analysis of the individual frameworks and initiatives in this diverse set, a number of overall themes emerged:

- Several frameworks already address all of the key criteria elements.
- Multi-level engagement is key.
- Priority topics for population health improvement are wide-ranging.
- Behavioral determinants of health are addressed very frequently.
- Planning appears to be more common than measuring success against goals.
- None of the frameworks include all of the content needed for implementation.
- Abundance of measure domains, measures, and data sources may be counter-productive.
- The format of tools helps to ensure their usefulness.

Specific insights also came to light during assessment of the overall mix of frameworks, 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.

These themes and insights are supported by summary descriptions of each framework and initiative, in addition to analysis of the characteristics of individual frameworks and the mix as a whole. The report concludes with a set of questions for the project Committee as they provide guidance regarding the next steps in developing the *Guide for Community Action.*

## Purpose, Audience and Scope of Environmental Scan

This report serves as a foundation for *Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities*, sponsored by the Department of Health and Human Services (DHHS). Ultimately, this project aims to support the National Quality Strategy goal of Healthy People and Healthy Communities. Pending approval from DHHS for continuation, this effort will result in production of a *Guide for Community Action* (*Action Guide*), a resource for groups at any level (local, state, regional) who are interested in working together to improve population health. This report identifies key elements of national, state, and local frameworks and initiatives essential for development of an evidence-based organizing framework for improving population health, along with related measures, data sources, tools, and other relevant resources.

While the *Action Guide* will be intended for use by groups in the field who are working on improving population health, the primary audience for this environmental scan is the multistakeholder committee

of national leaders convened by the National Quality Forum (NQF) to drive the development and refinement of the *Action Guide.* Additional audiences for this report include leaders from an array of federal agencies working in close partnership with NQF on this project, and a spectrum of individuals interested in population health improvement.

This report builds on *An Environmental Scan of Integrated Approaches for Defining and Measuring Total Population Health*,[2] commissioned by NQF in 2012. Jacobsen and Teutsch established definitions for key concepts and a list of recommendations that provided a starting point for this environmental scan, including criteria that were used to assist with selection of the 40 frameworks and initiatives addressed in this report. Given the tremendous amount of research and thousands of programs focused on population health improvement, this report was designed to gather a representative range of examples that present a strong cross-section of insights.

## Practical Challenges

Population health improvement is a high priority and the need is great. Evidence abounds regarding the poor health status of the total population in the United States, with great disparities for many subpopulations as well. Researchers and program implementers across the country are diligently working to inform and improve efforts to address population health. Given the wide variety of existing research and related conceptual frameworks and programs/initiatives being implemented at the local, state, and regional levels, there are thousands of options for what could have been included in this environmental scan.

In considering the approach to this report, several practical challenges should be noted:

- Historically, many of the sectors involved in population health improvement have operated in separate silos. For example, public health practitioners often have a distinctly different focus from medical care providers, and individuals working in places like schools, jails, or transportation facilities may have limited opportunities to address health issues in the populations they serve. The funding, incentives, culture, and readiness to collaborate to improve population health vary widely.

- For some, working on population health is not new and there is a long history and deep experience. For others, this is a new field in large part because of the traditional silos.

- This report intends to bridge different cultures and approaches, by making the following assumptions:

    - Health must be viewed holistically – the state of wellness rather than merely the absence of disease.

    - Ideal approaches will be broad in some cases and very specific in others, given the mix of the frameworks and initiatives.

    - Issues around sustainability, cost-effectiveness, and scalability must be addressed to ensure viability for the approaches to be included in the *Action Guide.*

- Equity must be front and center, with particular attention to eliminating disparities and achieving health for everyone, no matter what the circumstance.

- This report intentionally attempts to address both visionary conceptual organizing frameworks to guide actions by others, in addition to learning directly from programs being implemented at the local, state, regional, and national levels.

- The methodology used to identify the 40 frameworks and initiatives addressed in this report does not imply that only the best are included. This is not an exact science. However, the approach did benefit from the guidance of some of the leading experts in population health improvement.

- This is an iterative process, which continues to be refined as the work progresses and new themes emerge. This continuous learning and adaption is expected to continue throughout this multiyear project.

## Key Terms and Assumptions

Given the diverse and expansive nature of population health improvement, it is important to clarify the meaning of words being used, and the assumptions that drive the project.

While the goal is to achieve a shared understanding and consistency in expectations regarding the scope and approach, the terms and their definitions listed below are a starting place. Over time, this list may expand, certain definitions may be refined, or specific words may be replaced with terms that are less apt to be misinterpreted by project participants or by the intended audience(s) of project materials.

1. **Community** – a group of people who have common characteristics; communities can be defined by geographic proximity, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other similar common bonds.[3]
2. ***Community Action Guide*** – the *Action Guide* is intended to be a practical resource for communities interested in improving population health. Possible content will include a recommended conceptual framework, in addition to tools, data sources, and measures (see other definitions) to ensure that the final *Action Guide* is useful. A matrix of the varied content of each of the frameworks assessed in this report can be found in Appendix B.
3. **Data sources** – specific resources where organizations can access useful data for measuring or assessing social, environmental, behavioral and/or clinical elements that impact population health. Preference will be given to data sources that are widely available; however, others may be included as good examples that could spur expanded data collection.
4. **Framework** – a *conceptual* structure that shows important elements or actions and their relationship to each other in addressing population health improvement. For purposes of this project, frameworks were identified from literature (peer-reviewed research, white papers, reports, etc.) or ascertained by assessing the underlying structure implied by a population health improvement initiative, program or approach. Higher priority was placed on evidence-based frameworks when available, recognizing that frameworks based on field implementation may not have undergone rigorous evaluation.
5. **Health** – a state of well-being rather than the absence of disease. This is consistent with the World Health Organization's definition, which has not been amended since 1948*:* "health is a state of

complete physical, mental and social well-being and not merely the absence of disease or infirmity."[4]

6. **Measures** – specific metrics (including indicators, rates, numerical counts, etc.) that clinical health care systems, public health agencies and/or other stakeholders can use to assess key aspects of and/or contributors to the health of a population. Relevant measures identified in working with the federal government and communities will be included in the *Action Guide*.
7. **Population health** – health of all people in a distinct group or subpopulation within a given geopolitical area. Examples include all people of a certain race, ethnicity, or age range; all individuals with a certain health condition; or groups such as employees and dependents. While preference will be given to conceptual frameworks that address *total* population health improvement, elements of the *Action Guide* (tools, measures, data) will likely address specific subpopulation health needs. Total population health refers to the health of all people within a geopolitical area.
8. **Tools** – items such as surveys, communication materials, online calculators or other apps, etc., that can be used in the process to improve population health. Relevant tools identified in working with the federal government and communities will be included in the *Action Guide* (see "Framework for Community Action" below).

## Methodological Approach

The analytic approach to the environmental scan was guided and informed by an Advisory Group consisting of a smaller subset of the full Committee of population health experts that NQF convened for this project. Additional input was also provided by the full Committee, federal partners engaged in this work, and from the Government Task Lead (GTL) overseeing this project. As a first step, criteria were developed to help pinpoint high-leverage frameworks and to define the scope of the initial analysis. The criteria against which the frameworks were assessed are listed below:

A. The framework involves two or ideally three of the following: public health, healthcare, and other stakeholders

B. The framework addresses as many as possible of the following nine key criteria elements:

    a. An organizational planning and priority-setting process
    b. A health and needs assessment process
    c. An agreed-upon, prioritized subset of health improvement activities
    d. Takes responsibility for leading a health improvement activity
    e. Selection of a set of measures or indicators and performance targets
    f. Use of those same prioritized indicators
    g. Joint reporting on progress toward achieving the intended results
    h. A plan for sustainability
    i. Indications of scalability

C. The mix of frameworks includes focus on high impact topics, reflects diversity (geographic, racial/ethnic, income), and addresses population health needs across the lifespan

The first two criteria were considered for each of the frameworks individually, and the third applied across the final pool to ensure the frameworks collectively achieved the diversity that was desired from

this purposive sample. A matrix of the elements of the second criteria used in this analysis and applied to each of the frameworks may be found in Appendix C.

In brief, work on the environmental scan began at the start of the project, knowing that this would be an iterative process with a high priority on full transparency. Starting with a broad scan for frameworks and initiatives to potentially include in the report, the project team identified 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. This included clarifying definitions and suggested criteria to use in narrowing the focus of the scan. The scope was then refined, with particular attention to the criteria that would frame the initial review and triage of the large number of identified frameworks and initiatives.

With the revised selection criteria and recommendations from federal agency partners and the Advisory Group in mind, approximately 10 percent of the 700+ candidates were chosen for further evaluation. Also making the shorter list were state or local initiatives associated with programs funded or supported by national groups such as the Robert Wood Johnson Foundation, the Office of the National Coordinator, and Centers for Medicare & Medicaid Services. The selection criteria were then further refined based on input of the Committee and HHS. The final criteria were applied considering the overall mix of the remaining frameworks to ensure that this report will cover a high impact, comprehensive and diverse set. Based on this categorization and feedback on the remaining candidates, 40 frameworks were selected for final inclusion.

The triage process helped shape the development of detailed informational elements that would be gathered for each of the 40 frameworks or initiatives. For example, it was clear that the assessment needed to accommodate the diversity in purpose, structure, focus, and content of the frameworks and initiatives. Some appeared to be pure conceptual frameworks, while many others are primarily projects being implemented in state or local communities. Still others are essentially tools or measure compendia. While this variety provided useful insights, it also made some aspects of the analysis irrelevant for certain frameworks. Questions regarding sustainability, scalability, and impact, for example, may not be relevant to a purely conceptual framework in a research paper.

For a more detailed description of the methodology, see Appendix A.

## Overall Analysis

A brief description of each of the 40 frameworks is provided in Appendix D. The deliberate selection of a diverse group of frameworks and initiatives resulted in an interesting range of approaches, focus areas, and content. However, the assessment of convergent and divergent themes was general in nature in part due to inclusion of different types of frameworks. In addition, while preference is given to evidence-based frameworks and initiatives, the mix included programs, tools, and other resources which may not have had the benefit of third party review to establish whether they are achieving identified goals and objectives. The majority of the frameworks and initiatives cite sources of evidence used as the basis for their work; however, in-depth evaluation of evidence was beyond the scope of this analysis, and specific research or other evidence may not always be cited within publicly available information.

The following themes emerged from the overall analysis:

- Several frameworks already address all of the key criteria elements.
- Multilevel engagement is key.
- Priority topics for population health improvement are wide-ranging.
- Behavioral determinants of health are addressed very frequently.
- Planning appears to be more common than measuring success against goals.
- None of the frameworks includes all of the content needed for implementation.
- Abundance of measure domains, measures, and data sources may be counter-productive.
- The format of tools helps to ensure their usefulness.

Each of these themes is described in further detail below.

## Several of the Frameworks Address All Key Criteria Elements

Each of the 40 frameworks and initiatives was assessed for addressing the 9 key criteria elements identified above (i.e., organizational planning and priority-setting process; health and needs assessment process; agreed-upon, prioritized subset of health improvement activities; taking responsibility for leading a health improvement activity; selection of a set of measures or indicators and performance targets; use of those same prioritized indicators; joint reporting on progress toward achieving the intended results; having a plan for sustainability; indications of scalability). Frameworks or initiatives were deemed to have addressed these elements if included as guidance for others to apply, or if incorporated directly as part of the structure of a program or initiative being implemented.

Among the 40 frameworks examined, 9 of these appeared to address all 9 of the key criteria elements. These include the *Beacon Community Program; County Health Rankings (Roadmap to Health); Healthy People 2020; Healthy Start Healthy Future for All;* the *National Prevention Strategy; the Practical Playbook; Project Healthy Grad; Vermont Blueprint for Health;* and the *White Earth Nation Tobacco Coalition*.

Looking across frameworks, at least half addressed each of the key criteria elements to some extent. Establishing a prioritized set of health improvement activities and engaging in an organizational planning and priority setting process were among the most commonly addressed elements. And because of the inclusive approach used to assess sustainability and scalability, these elements were also seen to be addressed quite frequently. Appendix C contains further details on the assessment of key criteria elements for each framework.

## Multi-Level Engagement is Key

Nearly all of the frameworks recognize the importance of involving stakeholders at more than one level (national, state, local), reflecting the multifaceted and interrelated nature of population health improvement. About one third of the frameworks include a specific multilevel approach to population health improvement, with some combination of action at the national, state, and/or local levels.

More than half of the frameworks are applied at the national level, while many of these also describe implications or desired actions at the state and community level. Examples include federal agency initiatives such as the *HHS Action Plan to Reduce Racial and Ethnic Disparities* and *Moving Healthy: Linking Federal Highway Administration Programs and Health*. Others assess and recommend federal

action, such as the *Primary Care and Public Health: Exploring Integration to Improve Population Health* and the *A Healthier America 2013: Strategies to Move from Sick Care to Health Care in Four Years.*

About a third of the frameworks are initiatives focused primarily at the state and community levels. Many of these make tools and other resources, such as lists of measures or databases of promising practices, available to others as well. Examples include the *Practical Playbook,* the *Camden Care Management Program and Cross-Site Learning*, and H*ealth in All Policies: A Guide for State and Local Governments*. The only framework included from outside the United States — the *National Service Frameworks* of the NHS — includes activities at the national and local levels in the United Kingdom.

## Priority Topics for Population Health Improvement are Wide-Ranging

A majority of the frameworks and initiatives speak generally to population health improvement, sometimes with no mention of a more specific focus. About a third of the frameworks include disparities reduction as an important priority. This is of particular note due to guidance from the Committee that special emphasis should be placed on disparities and improving health equity.

The table below shows the frequency with which various topics appeared to be addressed as a prominent focus within the mix of the forty frameworks.

| Topic | # of Frameworks (Out of 40 total) |
|---|---|
| General health | **30** |
| Disparities/Equity | **11** |
| Behavioral health | **9** |
| Obesity | **9** |
| Tobacco | **8** |
| Cardiovascular health | **7** |
| Diabetes | **7** |
| Education | **6** |
| Health information management/Exchange | **6** |
| Maternal and infant health | **5** |
| Tribal health | **3** |
| Safety | **3** |
| Corrections | **2** |
| Cost | **2** |
| Injury prevention | **2** |
| Other: Access to and use of services; Aging; Cancer; Chronic pain, Drug abuse; Emergency preparedness; Environmental health; Food safety; Infectious diseases; Low income; Multiple chronic conditions; Nutrition; Physical activity; Transportation; Super-utilizers; Stable housing; Violence, abuse, or neglect | **1** |

## Behavioral Determinants of Health are Addressed Frequently

Across these frameworks and initiatives, four key influencers of population health — behavioral factors, physical environment, social structures, and health care — were commonly highlighted. This alignment in focus is notable given the diversity in the mix of frameworks and initiatives. A strong majority of the frameworks and initiatives address three or four of these determinants of health. Of the six frameworks that address only one or two of these areas, five focus on behavioral determinants of health. In fact, nearly all of the frameworks address behavioral determinants of health in some way.

*Health in All Policies: A Guide for State and Local Governments* captures the importance of considering broad influences on health quite well, recognizing that "the greatest health challenges—for example, chronic illness, health inequities, climate change, and health care costs—are highly complex and often linked. Promoting healthy communities requires addressing the social determinants of health, such as transportation, education, access to healthy food, economic opportunities, and more."[1] This framework also includes a comprehensive set of measurement domains, reflecting the elements that constitute a "healthy community."

For each of the determinants of health, the frameworks and initiatives offer a wealth of examples of interventions and related tools, measures, and data sources that apply to each. Listed below are just a handful of the most compelling examples of addressing behavioral, environmental, and social determinants drawn from the 40 frameworks.

**Behavioral Determinants.** As noted, nearly all of the frameworks and initiatives place weight on impacting individual behavior in some manner to improve health. The most frequent examples were: promoting physical activity; education regarding portion size and proper nutrition; and reducing tobacco use. The locations where such interventions take place span quite a range, including workplaces, primary care clinics, dedicated wellness centers on military bases, classrooms, and jails. Certain initiatives stand out:

- **White Earth Nation Tobacco Coalition**. This group takes a *culturally based approach* to reduce tobacco use. Because of the role that tobacco plays in the life of the tribe, they discourage using "commercial tobacco" and emphasize that Asayma (their traditional name for tobacco) is to be used in prayer and should not be inhaled. Similarly, the Wellness Warriors program encourages Native Alaskans to seek healthy and safe relationships, recognizing the spiritual, emotional, and physical effects of violence and abuse.

- **Early Education Readiness Using a Results-Based Accountability Framework**. This program takes an *expansive view of improving kids' readiness for school*. Interventions include getting families to pledge to make "parent-child quality time" more deliberately structured to help their children learn skills important for school readiness.

- **Healthy Start, Healthy Future for All**. To reinforce nutrition education for families, this program *offers healthy meals to kids on the weekend* to ensure that healthy eating is available even when not in school. They also run *Baby Cafés,* creating a social place for new mothers with babies to gather and access lactation care and support.

- **Blue Zones**. This project promotes nine basic behaviors that lead to longevity, based on evidence from communities across the globe. The "Power Nine" is described in simple words (e.g., eat more plants, move more) and address physical, social, and spiritual needs. Through individuals and those who impact the choices of individuals — such as employers, schools, and community leaders — Blue Zones encourages pledges to commit to living, and supporting others to live, consistently with the Power Nine.

**Environmental Determinants.** Changing the environment to enable better health may seem daunting; however, several types of interventions appeared with some frequency: elevating the importance of public health functions; creating a "culture of healthy living" through physical proximity to better food choices and redesigned surroundings to encourage physical activity; and creating smoke-free environments. These interventions are being done in the workplace, military bases, schools, parks, museums, gardens, and in communities at large. Certain initiatives stand out:

- **Moving Healthy: Linking FHWA Programs and Health**. This national framework highlights the powerful impact that transportation planning has on the environment and health. For example, FHWA uses the National Environmental Policy Act 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 and recreational and cultural resources; environmental justice; water quality; and access to safe transportation systems.

- **Green Strides.** An education-based program aimed at creating "green" school facilities. Actions focus on ways to reduce the environmental impact of school buildings, while using the opportunity to educate kids about the importance of health and sustainability. Schools can earn recognition by being certified as a "Green Ribbon School."

- **Camden Care Management Program & Cross Site Learning.** Primarily healthcare oriented, this project also recognizes the essential importance of housing on the health of individuals. Through coordination with social service providers, they ensure that patients have a place to live, either in temporary shelters or longer-term arrangements.

**Social Determinants.** Even more challenging, improving the social and cultural structures that can be barriers to good health are addressed in a number of the frameworks and initiatives. Efforts to reduce disparities are often the driving force behind these approaches. Examples include improving educational attainment, securing government benefits and tuition assistance, building career skills, and creating stronger personal and spiritual connections. Several of the frameworks or initiatives called out the importance of changing social mores and public policy to reduce barriers created by social and cultural issues. Some notable examples include:

- **Healthy Memphis Common Table**. This program works to "Lift All Voices" by improving health literacy among people with low literacy. Presenting health knowledge as an issue of personal empowerment is a unique approach that hopes to create social change beyond simply educating a person about his or her own health and healthcare.

- **Project Healthy Grad.** This initiative recognizes the important link between health and academic success. Improving health and wellness in students can facilitate better learners, and individuals with more education are more likely to live longer and healthier lives.

## Planning Appears to be More Common than Measuring Success Against Goals

Even though organizational planning is common, the practice of setting specific goals or objectives against which to measure success does not appear to be as prevalent or, at a minimum, it is not information that is often shared publicly. Nearly all of the information used to assess the 40 frameworks and initiatives was gathered through publicly available sources, so it is possible that the programmatic goals and the evidence of achieving those goals are not routinely available in reports and public websites.

About half of the frameworks mention specific objectives or goals, and several include information about their successes thus far. Notable examples include *Hennepin Health*, which provides extensive information regarding their progress toward meeting goals for individual quality of life improvement, reducing disparities, cost reduction, and provider and staff experience; *Vermont Blue Print for Health* publishes an annual report listing goals and progress to achieving them; several of the federal frameworks (*Let's Move; the National Quality Strategy; the National Prevention Strategy; Healthy People 2020;* and *the Beacon Community Program*) describe progress toward achieving goals or meeting milestones, and some are frank about results thus far being mixed.

Many initiatives describe success stories, rather than providing numeric assessments indicating their progress. Some programs have goals regarding expansion of participation by stakeholders or use of their services. For example, the *Regional Equity Atlas 2.0* assesses use of their interactive tool to determine success. The *Guide to Community Preventive Services* tracks utilization of the guide. Similarly, the *Correctional Health Outcomes and Resource Data Set* has been able to secure participation by more than 56 prisons and 10 jails, and the number is growing. While they measure and share information based on diabetes measures, at this stage in the program development improving health status is secondary to creating a more robust and coordinated approach to systematic correctional health improvement with similar efforts outside the prison walls.

## None of the Frameworks Include All Content Needed for Implementation

This diverse mix of frameworks and initiatives was selected to ensure that it would include examples that offer one or more of the following core types of content important for practical implementation:

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(s)
D. Population health improvement program being implemented
E. Measure domains or measures
F. Tool(s)

The majority of frameworks reviewed contain more than one of these content types, with many addressing several. However, none of the frameworks included content addressing all six types.

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.**

a) Many initiatives and frameworks contain useful tools, but few cite evidence or research as the basis for the tools; must these resources be "evidence-based" to be included in the *Action Guide*?

b) Should the *Action Guide* reference any measures, data sources, or tools that are only available to people for a fee (e.g., dues paying members or customers)?

5) **How should the concepts of sustainability and scalability be defined and applied when determining appropriate content for the *Action Guide*?**

a) In the context of the *Action Guide,* is the concept of scalability relevant to a conceptual framework, insight from a program or initiative, a measure set, data source, or tool? What definition and parameters can be used to determine whether each of the relevant elements is "scalable"?

b) In the context of the *Action Guide,* is the concept of sustainability relevant to a conceptual framework, insight from a program or initiative, a measure set, data source, or tool? What definition and parameters can be used to determine whether each of the relevant elements is "sustainable"?

6) **Definition of terms.** What key terms should be defined in the *Action Guide*?

7) **Format.** A key insight from the initiatives is the usefulness of online and interactive resources. Should the *Action Guide* be developed with the goal of putting it in some type of dynamic format (e.g., online tool) versus a static report (e.g., print, PDF)?

a) **Pro**: Enables the *Action Guide* to "walk the talk" regarding effective communication and stakeholder engagement; allows useful resources to be linked and avoids duplicating content; enables the *Action Guide* to be current and updated

b) **Con**: Requires a commitment of resources to maintain the online *Action Guide*

8) **Feedback Communities.** Given the chosen approach to the *Action Guide* content and format, what are the implications for the Feedback Communities?

a) What outcomes are expected from working with Feedback Communities?

b) What is the role of and expected level of engagement by the Feedback Communities?

c) What key questions will be posed to the Feedback Communities for their consideration when testing the *Action Guide* and informing its refinement?

d) Based on expectations, what criteria should be used to select Feedback Communities?

## Summary/Conclusion

The journey is not brief nor the path straightforward; however, the importance of the destination is without doubt.

The insights described in this report are possible only because of the tremendous work done by thousands of dedicated people working on improving the health of communities. Building on this rich history and the leading edge of the quickly evolving health policy environment, this report intends to further the shared learning based on a range of frameworks and initiatives — reflecting academic research, assessments and recommendations from professional societies and associations, government programs and policies, and projects run by a multitude of individuals committed to improving health in many communities.

Such diversity in the approach taken within this environmental scan is a deliberate attempt to recognize and support the practical truth that improving population health is not a simple endeavor, nor is it something that a single organization or sector can accomplish alone.

The wealth of organizing structures, program examples and ideas, measure sets, data sources, tools, and stated priorities currently available to address the social, environmental, and behavioral determinants of health may be at risk of becoming "white noise" because of the sheer volume, complexity of the issues, and lack of coordination.

But with the insights and themes identified in this report, and guided by further discussion around the key questions and considerations, the next steps will hopefully be a bit clearer for moving forward in creating a *Guide for Community Action* that is useful for communities across the country.

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1 *Health In All Policies: A Guide for State and Local Governments*, produced by the Public Health Institute, the California Department of Public Health, and the American Public Health Association, 2013

2 Jacobsen, DM, Teutsch S*. An Environmental Scan of Integrated Approaches for Defining and Measuring Total Population Health by the Clinical Care System, the Government Public Health System, and Stakeholder Organizations*. 2012. Available at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=70394.

3 *Public Health: What It Is and How It Works.* Fourth Edition. Boston: Jones and Bartlett, 2009.

4 Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

## Appendix A
## Methodology Detail

As soon as the Task 4 project began, work on the environmental scan started immediately. Understanding that there are thousands of population health initiatives at the local, state, and federal levels across the country, the project team took an iterative approach, placing high priority on full transparency and using publicly available information drawn from websites, reports, and other documents. The frameworks and initiatives ultimately included in this report were selected using a key informant strategy, triangulated through face validity in collaboration with experts from HHS and the Advisory Group, then rated against initial criteria and descriptive information. The overall narrowing approach is depicted in Figure 1 below, starting at the bottom and working up, and explained in the subsequent narrative.

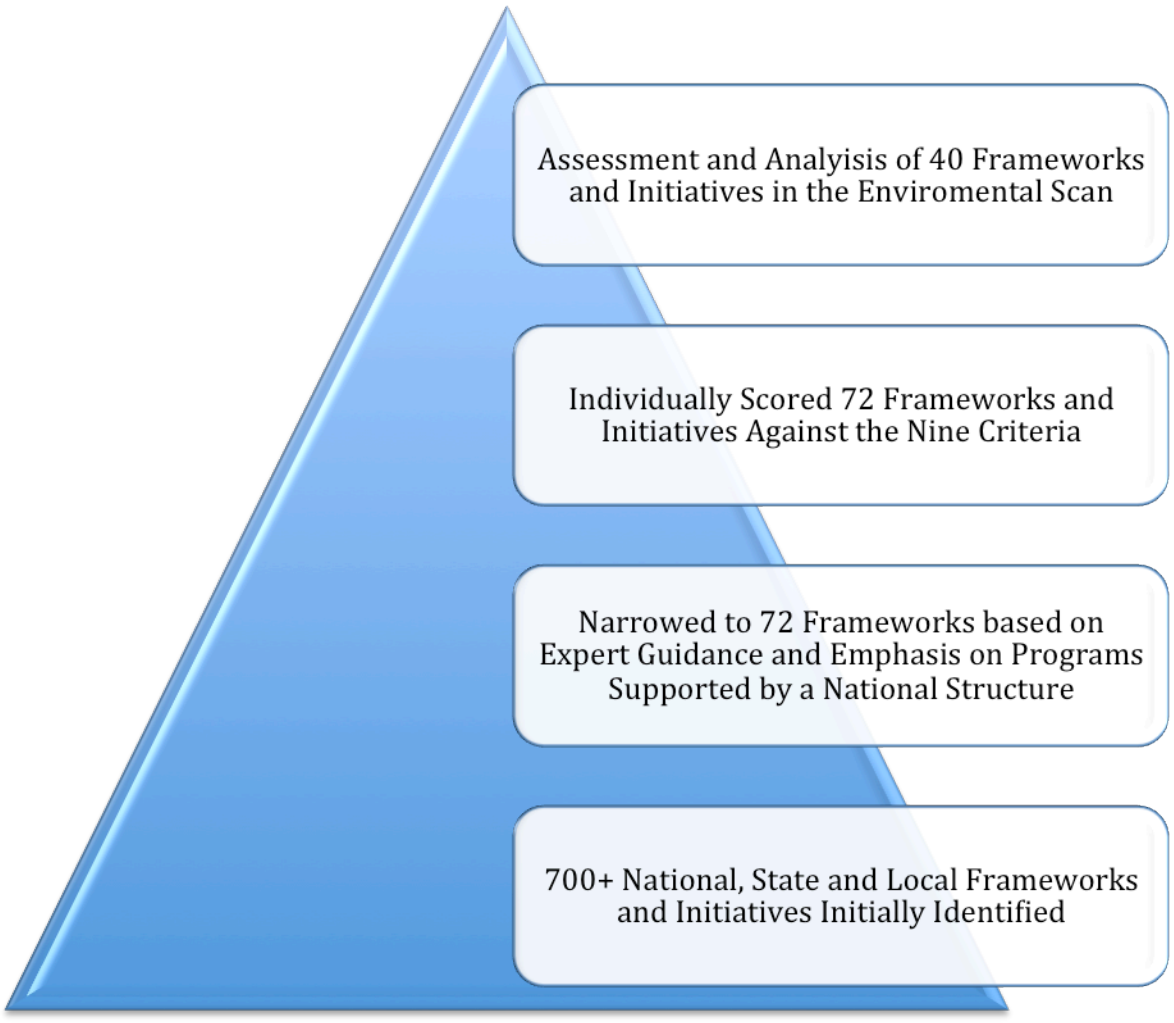


**Figure 1 shows the four steps used to narrow from 700+ to 40 frameworks and initiatives in the report**

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

to the health improvement activities noted under item C above. [*at the subpopulation level.*]

g. Jointly report on progress toward achieving the intended results for both subpopulation and total population health outcomes

h. A plan for how the population health improvement activities will be sustained

i. Indications that the framework or initiative is scalable

*Collective Criteria.*

1. The mix of frameworks should reflect health improvement in populations where there is likely the greatest potential for impacting total population health (e.g., high impact need, topic or condition)
2. The mix of frameworks should address health improvement in populations across the lifespan (health needs affecting individuals at various stages, birth to end of life)
3. The mix of frameworks should reflect diversity (e.g., geographic, urban/rural, race/ethnicity/language, income)

With these criteria in mind, about 10 percent of the more than 700 candidates were selected and further vetted based on recommendations from federal agency partners, national experts in population health and public health, and prior population health research. Also included on the shorter list were state or local initiatives associated with programs funded or supported by national groups such as the Robert Wood Johnson Foundation, the Office of the National Coordinator, and Centers for Medicare & Medicaid Services.

Using the individual and collective criteria as a guide, the list was winnowed to 72 frameworks or initiatives. The project team collected basic information and scored each of the 72 frameworks, using the individual criteria. The frameworks or initiatives which appeared to meet more of the criteria had higher scores. Using the collective criteria, the overall mix was assessed to ensure that this environmental scan would include a high impact, comprehensive, and diverse set overall. After reviewing the scoring and final assessment of the 72 candidates, 40 were selected.

This stage of the triage process, involving nearly twice as many frameworks and initiatives than are described in this final report, helped shape the development of detailed list of informational elements that would be gathered for the final 40. Assessment elements needed to accommodate the diversity in the selected mix regarding purpose, structure, focus, and content. Some appeared to be purely conceptual frameworks, while many others were clearly projects being implemented in state or local communities. Still others were seen primarily as tools or measure compendia. It was determined that certain additional criteria suggested by the Advisory Group — such as addressing sustainability, scalability and impact, for example — may need to be applied using slightly different framing depending on the nature of the framework or initiative. Some criteria may not prove to be relevant to every type of framework or initiative, such as whether a research paper on measurement domains is “sustainable” or a tool that provides a national data source can be easily replicated or scaled.

In addition, to ensure that the assessment of each individual framework or initiative would provide all of the information needed to conduct the analysis, the team developed a draft outline for this report. That

exercise highlighted even more data elements that would be needed and key distinctions to make, such as noting when a "conceptual framework" helps guide community engagement in improving population health, versus "conceptual frameworks" meant to drive actions to improve a particular aspect of population health such as obesity, safe neighborhoods, or reduced tobacco use.

Using publicly available information sources such as published reports and websites, information was gathered for each of the 40 frameworks or initiatives. In a few instances, more information was gathered through direct contact, although time was a limiting factor. The types of information collected on the 40 frameworks and initiatives are listed below.

1. What is it?
    a) A conceptual *framework for engaging a community in population health improvement*
    b) A conceptual *framework of activities that improve health* within a population
    c) A *program or initiative being implemented to improve health* in a specific population
    d) A *tool* to support population health improvement
    e) A *set of measure domains and/or measures* to assess population health improvement
    f) A *data source* to use in assessing population health improvement
    g) Other

2. Location and focus level (e.g., national, state, local; public and/or private)

3. Specific topic focus area(s) targeted
    a) Behavioral health (i.e., mental health and/or chemical dependency)
    b) Cardiovascular health
    c) Corrections
    d) Diabetes
    e) Disparities/Equity
    f) Education
    g) General
    h) Health Information Management/Exchange
    i) Maternal/Infant Health
    j) Obesity
    k) Rural Health
    l) Safety
    m) Tobacco
    n) Tribal Health
    o) Violence, Abuse, or Neglect
    p) Other (describe: )

4. Is evidence (third party studies, research in peer-reviewed literature) cited for the framework, program, tools, etc?

5. Which of the following key criteria elements appear to be present? *(note: for conceptual frameworks, this is about elements that are being encouraged for others to implement; for programs or initiatives, this is about elements that they are implementing)*

a) An organizational planning and priority-setting process
b) An integrated community health and needs assessment process that includes the synergistic needs of all respective organizations
c) An agreed-upon, prioritized subset of health improvement activities where respective organizations direct resources and/or develop capacities to deliver them
d) Responsibility for leading a health improvement activity (process, intervention, or policy activity) within the geopolitical area
e) Selection of an integrated and complementary set of measures and performance targets
f) Use of those prioritized indicators of health outcomes and determinants of health measured at the total population level, clearly linked to the health improvement activities
g) Reporting on progress toward improving population health outcomes
h) Sustainability
i) Scalability

6. Which of the following determinants of health are addressed?

a) Behavioral (individuals' actions)
b) Environmental (physical surroundings)
c) Social (societal structures)
d) Healthcare (from service providers)
e) Other:

7. Which types of stakeholders are involved?

- Business / Employers
- Churches / faith community
- Consumer groups
- Corrections / Jails
- Health facilities
- Health plans / insurers
- Health practitioners
- Housing
- Individuals
- Military
- Minority groups
- Multistakeholder alliances
- Nonprofit, private social service groups
- Public health department / agency
- Public agency (social service, other government)
- Schools / Education

- Tribes
- Unions
- Other:

8. Are there domains being measured? Specific measures being used?

9. For any measures or indicators, what are the data sources used?
   a) Administrative claims (health plan data)
   b) Clinical data from healthcare providers (electronic format or paper chart)
   c) Public health data (describe)
   d) Surveys (consumers / patients / individuals, others)
   e) Other

10. Does the framework / initiative create a data source available for use by others? Do they use data sources created by others?

11. Does the framework or initiative create or use tools to assist in assessing, planning, and undertaking interventions to improve population health?

12. Is there evidence that the framework or initiative is achieving its goals?

13. Does the framework or initiative define and/or use specific terminology?

14. Does the framework or initiative include a sustainability plan?

15. Does the framework or initiative appear to be scalable?

16. Is there something unique or particularly interesting about this framework or initiative?

17. Does the framework or initiative present key lessons?

18. Are there other questions or issues that need to be explored for this framework or initiative?

Once this information was collected, the project team compared and contrasted the results to reveal themes, observations and recommendations described in the main body of this report. Based on guidance from experts on the project Committee, including the Advisory Group, certain aspects of the analysis in this report may call for direct contact with leaders associated with particular frameworks or initiatives in order to inform the development of the *Action Guide*.

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1 Jacobsen, DM, Teutsch S. *An Environmental Scan of Integrated Approaches for Defining and Measuring Total Population Health by the Clinical Care System, the Government Public Health System, and Stakeholder Organizations*. 2012. Available at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=70394.

## 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 | Total |
|---|---|---|---|---|---|---|---|
| Green Strides | | x | | x | | x | 3 |
| HCI CHNA System and Healthy Communities Network | | | x | x | x | x | 4 |
| Health Impact Pyramid | | x | | | | | 1 |
| Health in All Policies: A Guide for State and Local Governments | x | x | x | | x | x | 5 |
| Healthy Base Initiative Demonstration Site – Ft. Meade, Maryland | | x | | x | | | 2 |
| Healthy Memphis Common Table | | x | | x | | | 2 |
| Healthy People 2020 | | x | x | | x | | 3 |
| Healthy Start, Healthy Future for All | | x | | x | | x | 3 |
| Hennepin Health | | | | x | x | x | 3 |
| HHS Action Plan to Reduce Racial and Ethnic Health Disparities | | x | | | | | 1 |
| HRSA Public Health Steering Committee Recommendations | | x | | | | | 1 |
| Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014 | | x | | x | x | x | 4 |
| Let's Move | x | x | | x | | x | 4 |
| 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 | 3 |
| National Service Frameworks | | x | x | x | x | | 4 |
| National Strategy for Quality Improvement in Health Care | | x | | | x | | 2 |
| Operation Live Well | | x | | x | | x | 3 |
| Pioneering Healthier Communities | x | x | | x | x | x | 5 |
| Practical Playbook | x | x | | | x | x | 4 |

| Name of Framework or Initiative | A | B | C | D | E | F | Total |
|---|---|---|---|---|---|---|---|
| Primary Care and Public Health: Exploring Integration to Improve Population Health | **x** | | | | | | 1 |
| Project Healthy Grad | | | | **x** | | **x** | 2 |
| Regional Equity Atlas 2.0 and Action Agenda | | | | | **x** | **x** | 2 |
| State Innovation Models Initiative (SIM) | | | | **x** | | | 1 |
| The Guide to Community Preventive Services | | | | | | **x** | 1 |
| Toward Quality Measures for Population Health and Leading Health Indicators | | **x** | | | **x** | | 2 |
| Vermont Blueprint for Health | | | | **x** | | | 1 |
| White Earth Nation Tobacco Coalition | | **x** | | **x** | | | 2 |
| **Total** | **11** | **29** | **9** | **23** | **18** | **22** | |

## Appendix C
## Matrix of Top 40 Frameworks in Relation to the Nine Key Criteria Elements

The table below indicates which of the nine key criteria elements are reflected in each of the 40 frameworks and initiatives. The letters in each column heading represent the following elements:

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. **An integrated community health and needs assessment** process [*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** [*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 to the health improvement activities [*at the subpopulation level.*]

G. **Jointly report on progress** toward both subpopulation and total population health outcomes

H. **Sustainability**: recommends use of a sustainability plan; has a sustainability plan in place; is grant or government funded*

I. **Scalability**: recommends that programs are designed to be scalable; states that the program is scalable or can be replicated by others

As a proxy for parameters that define Sustainability in column H, several different conditions were considered as meeting this criterion. Those conditions are coded separately in the column and defined at the end of the matrix below.

| Name of Framework or Initiative | A | B | C | D | E | F | G | H | I | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| A Healthier America 2013: Strategies to Move from Sick Care to Health Care in Four Years | x | x | x | | | | x | IN | x | 6 |
| ACHI Community Health Needs Assessment Toolkit | x | x | x | | x | | x | | x | 6 |
| Beacon Community Program | x | x | x | x | x | x | x | GR | x | 9 |
| Blue Zones Project | | | x | x | | | | | x | 3 |
| Camden Care Management Program and Cross-Site Learning | x | | | x | x | x | | IN | x | 6 |

| Name of Framework or Initiative | A | B | C | D | E | F | G | H | I | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Clinical-Community Relationships Measures Atlas | | | x | | | | | | x | 2 |
| Community Transformation Grants | x | x | x | x | | | | GT | x | 6 |
| Correctional Health Outcomes and Resource Data Set | | | | | x | x | x | | x | 4 |
| County Health Rankings & Roadmaps to Health | x | x | x | x | x | x | x | IN | x | 9 |
| Early Education Readiness Using a Results-Based Accountability Framework | x | x | x | x | x | x | x | | x | 8 |
| Family Wellness Warriors Initiative | x | x | x | x | | | | IN | x | 6 |
| For the Public's Health: The Role of Measurement in Action and Accountability | | | | | x | | x | | x | 3 |
| Green Strides | x | | x | x | | | | GR | x | 5 |
| HCI CHNA System and Healthy Communities Network | x | x | | | x | | x | SP | x | 6 |
| Health Impact Pyramid | | | x | | x | | | IN | x | 4 |
| Health in All Policies: A Guide for State and Local Governments | x | x | x | | | | | IN | x | 5 |
| Healthy Base Initiative Demonstration Site – Ft. Meade, Maryland | | | x | x | | | | | x | 3 |
| Healthy Memphis Common Table | x | x | x | x | x | x | x | | x | 8 |
| Healthy People 2020 | x | x | x | x | x | x | x | GT | x | 9 |
| Healthy Start, Healthy Future for All | x | x | x | x | x | x | x | GR | x | 9 |
| Hennepin Health | | | | x | x | x | x | | x | 5 |
| HHS Action Plan to Reduce Racial and Ethnic Health Disparities | x | | x | | | | | GT | x | 4 |
| HRSA Public Health Steering Committee Recommendations | x | | x | | | | x | | x | 4 |
| Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014 | x | | x | x | x | x | x | GR | x | 8 |
| Let's Move | x | x | x | x | | | | GT | x | 6 |

| 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
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## Current Activities in Population Health Measurement

In its 2008 report, *National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare*, the NQF-convened National Priorities Partnership (NPP) identified population health as one of six priority areas for national action. NPP envisioned "communities that foster health and wellness as well as national, state, and local systems carefully invested in the prevention of disease, injury, and disability—reliable, effective, and proactive in helping all people reduce the risk and burden of disease." NPP furthered this vision in 2011 during the development of the National Quality Strategy (NQS) priorities and goals, offering recommendations to ensure that the NQS focused not only on clinical preventive services, but also on behavioral, social, and environmental determinants of health in addition to working with communities to promote health and well-being.

That same year, NQF began a two-phase project, funded by HHS, which focused on identifying, endorsing, and updating population health measures. Phase I sought to maintain and expand previous efforts in measuring clinical prevention and immunization. Phase II focused on broader population-level measures. To kick off the project, NQF commissioned the Los Angeles County of Public Health and the Public Health Institute to develop a paper which:

- presented an environmental scan of existing measures and community health priorities;
- proposed analytic frameworks for assessing and measuring population health;
- discussed how to align the clinical care and public health systems;
- outlined methodological issues in population health measurement; and
- addressed gaps in community and population-level measurement.

The final commissioned paper developed additional guidance and context for measures addressing population health issues. This guidance included developing standardized definitions for population-level measure criteria, as well as a standardized framework to help measure developers understand what type of measures the steering committee aimed to endorse. This paper also highlighted issues surrounding accountability for population-level metrics.

This year NQF has undertaken several new projects in the area of population health measurement.

**Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities**

In the first year, NQF will conduct an environmental scan of up to 40 federal, state, and local frameworks including tools, data, and measures that are used to improve population health.

This work will serve as the foundation of the draft, evidence-based Community Action Guide that will be used to assess, plan for, and undertake interventions to address behavioral, social, and environmental determinants of health in communities nationwide. In follow-up years, NQF will obtain feedback on the draft framework from feedback communities that desire or are already working to improve population health and produce a final Community Action Guide.

## Population Health Family of Measures

To promote alignment of performance measurement across the healthcare continuum, the Measure Applications Partnership (MAP) has identified families of measures—sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS priorities and high-impact conditions. Families indicate the highest priorities for measurement and best available measures within a particular topic, as well as critical measure gaps that must be filled to enable a more complete assessment of accountability and payment programs. In 2014, the MAP will develop a family of measures that addresses population health.

## Health and Well-Being Endorsement Project

As an extension of NQF's previous work in population health measurement, this project seeks to identify and endorse measures that can be used to assess health and well-being across all levels of analysis, including healthcare providers and communities. The project will evaluate measures that assess health-related behaviors (e.g., smoking, diet, exercise, substance use); community-level indicators of health and disease (e.g., disease incidence and prevalence); primary prevention and screening (e.g., influenza immunization); practices to promote healthy living; community interventions (e.g., mass screening); and modifiable social, economic, environmental determinants of health with demonstrable relationship to health and well-being. During this project, 29 NQF-endorsed measures that are due for maintenance will be re-evaluated. These include measures that address community-level indicators, such as preventable admissions related to diabetes and social and environmental determinants of child health, as well as individual-level measures of health and well-being.

NATIONAL QUALITY FORUM

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**Multistakeholder Input on a National Priority:**
**Improving Population Health by Working with Communities**

# Project Brief

## Project Description

Under the guidance of a multistakeholder committee the National Quality Forum (NQF) will develop an evidence-based Community Action Guide that can be used by communities to improve population health. The guide will offer practical guidance on how communities can work with public health and clinical care systems to improve population health and will include shared definitions to ensure better coordination and alignment across these systems.

## Project Goals and Scope

*Base year (project year one):* The base year of this project will include the development of an environmental scan of up to 40 federal, state, and local frameworks including tools, data and measures that are used to improve population health. This work will serve as the foundation of the draft evidence-based Community Action Guide that can be used to assess, plan for, and undertake interventions to address behavioral, social, and environmental determinants of health in communities nationwide.

- Deliverable: First draft of the Community Action Guide

Option year one (project year two): NQF will obtain feedback on the draft framework from up to ten (10) Feedback Communities (FBCs) that desire or are already working to improve population health and are willing to adopt the guide for population health improvements. They will provide input on its usefulness, reliability, barriers with implementation, solutions and other valuable feedback.

- Deliverable: Evolved draft of the Community Action Guide (includes analysis of FBCs' experiences with implementation)

Option year two (project year three): With input from the FBCs and the Committee, NQF will finalize the Community Action Guide. (FBCs and the Committee will work collaboratively to address the concerns raised during option year 1.)

- Deliverable: Final Community Action Guide

**Role of the Committee and Advisory Group**

In consultation with HHS and through an open and transparent process NQF will convene a multistakeholder group of no more than 25 members with diverse expertise in the areas of population and community health, public health, healthcare, home- and community-based services, social services, purchasers, payers, employers, consumers and consumer advocates, and others who influence population health.

In the base year (project year one), the committee will,

- provide input on the analysis of state, local, and federal frameworks included in the environmental scan; and
- develop the first draft of the Committee Action Guide for implementation in option year one.

In option year one (project year two), the committee will,

- identify and recruit FBCs.

In option year two (project year three), the committee will,

- evaluate and respond to FBCs' input to ensure the guide addresses their needs; and
- champion the Final Community Action Guide.

NQF appointed a small Advisory Group of eight (8) members to guide all stages of the work. This group is a representative subset of the larger multistakeholder committee. The Advisory Group will assist with initial scoping of the environmental scan and identify frameworks in the base year; assist with developing the initial criteria for selecting Feedback Communities in option year one; and provide ongoing guidance on the evolving Community Action Guide development.

NATIONAL QUALITY FORUM

# Roster & Biographies

## Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities—Population Health Framework

### Committee Roster

Co-Chairs

**Kaye Bender, PhD, RN, FAAN**
Public Health Accreditation Board, Alexandria, VA

**Bruce Siegel, MD, MPH**
America's Essential Hospitals, Washington, DC

Members

**Catherine M. Baase, MD**
Dow Chemical Company, Midland, MI

**Georges C. Benjamin, MD, FACP, FACEP**
American Public Health Association, Washington, DC

**Christina Bethell, PhD, MBA, MPH**
Child and Adolescent Health Measurement Initiative, Portland, OR

**Kevin L. Bowman, MD, MBA, MPH**
WellPoint, Inc., Baltimore, MD

**Debra L. Burns, MA**
Minnesota Department of Health, St. Paul, MN

**JoAnne M. Foody, MD, FACC, FAHA**
Harvard University and Brigham and Women's/Faulkner Hospital, Boston, MA

**Beverly Franklin-Thompson, PharmD, MBA**
GlaxoSmithKline, Piney Flats, TN

**Reneé Frazier, MHSA, FACHE**
Healthy Memphis Common Table, Memphis, TN

**Rahul Gupta, MD, MPH, FACP**
Kanawha-Charleston and Putnam Health Departments, Charleston, WV

**Shelley B. Hirshberg, MA**
P2 Collaborative of Western New York, Williamsville, NY

**Charles J. Homer, MD, MPH**
National Initiative for Children's Healthcare Quality, Boston, MA

**Paul E. Jarris, MD, MBA**
Association of State and Territorial Health Officials, Arlington, VA

**Keith C. Kosel, PhD, MHSA, MBA**
VHA Inc., Irving, TX

**Jeffrey Levi, PhD**
Trust for America's Health, Washington, DC

**Doris Lotz, MD, MPH**
New Hampshire Department of Health and Human Services, Concord, NH

**J. Lloyd Michener, MD**
Duke University Medical Center, Durham, NC

**Doriane C. Miller, MD**
Center for Community Health and Vitality of the University of Chicago Medical Center, Chicago, IL

**David B. Nash, MD, MBA**
Thomas Jefferson University, Philadelphia, PA

**David Stevens, MD**
National Association of Community Health Centers, Bethesda, MD

**Matthew Stiefel, MS, MPA**
Kaiser Permanente, Oakland, CA

**Steven M. Teutsch, MD, MPH**
Los Angeles County Department of Public Health, Los Angeles, CA

**Julie Trocchio, RN, MS**
Catholic Health Association of the United States, Washington, DC

## Committee Biographies

### Co-Chairs

**Kaye Bender, PhD, RN, FAAN**, is the President and CEO of the Public Health Accreditation Board, a position she held part-time since January 2009 and currently holds full-time since June 2009. She has over 26 years of experience in public health working at both the state and local levels within the Mississippi Department of Health. Her last position there was as Deputy State Health Officer. Dr. Bender also served as Dean of the School of Nursing and Associate Vice Chancellor for Nursing at the University of Mississippi Medical Center in Jackson. She continues to teach two courses in health systems management and population health as a part-time Professor in the School of Nursing and the School of Health Related Professions at the University of Mississippi Medical Center. Dr. Bender served on the Institute of Medicine study committees for "The Future of the Public's Health in the 21st Century" and "Who Will Keep the Public Healthy." She currently serves as Chair of the APHA Education Board and served as Chair of the Public Health Leadership Society.

**Bruce Siegel, MD, MPH,** has an extensive background in healthcare management, policy, and public health. Dr. Siegel is President and CEO of America's Essential Hospitals (formerly the National Association of Public Hospitals and Health Systems). Before joining America's Essential Hospitals, he served as Director of the Center for Health Care Quality and Professor of Health Policy at The George Washington University School of Public Health and Health Services. He also previously served as President and CEO of two of the largest healthcare systems in the United States and Commissioner of Health for the State of New Jersey. Dr. Siegel is a leader on quality and equity conducting projects for the Robert Wood Johnson Foundation, the Commonwealth Fund, the California Endowment, and the Agency for Healthcare Research and Quality.

### Members

**Catherine M. Baase, MD,** is the Global Director of Health Services for The Dow Chemical Company, with direct responsibility for leadership and management of all Occupational Health, Epidemiology, and Health Promotion programs and staff around the world. In addition to these roles, Dr. Baase drives the Dow Health Strategy for employees, retirees, and their families. She is also involved with health policy and issues management. Previously, Dr. Baase served as Director of Health Care Strategic Planning with direct responsibility for Dow's US health benefit plans. She chairs the Executive Council of the Michigan Health Information Alliance (MIHIA), a multi-stakeholder collaborative dedicated to improving the health of people in central Michigan through the innovative use of information. MIHIA is a Chartered Value Exchange (CVE) as appointed by the Agency for Healthcare Research and Quality (AHRQ). She serves as an officer and is on the Board of Directors for the Partnership for Prevention, an organization dedicated to advancing policies and practices that make disease prevention a national priority.

**Georges C. Benjamin, MD, FACP, FACEP**, is well-known in the world of public health as a leader, practitioner and administrator. Dr. Benjamin has been the Executive Director of the American Public Health Association, the nation's oldest and largest organization of public health professionals, since December 2002. He came to

that post from his position as Secretary of the Maryland Department of Health and Mental Hygiene. Dr. Benjamin started his medical career in 1981 in Tacoma, WA, as Chief of the Acute Illness Clinic at the Madigan Army Medical Center. A few years later, he moved to Washington, DC, where he served as Chief of Emergency Medicine at the Walter Reed Army Medical Center. After leaving the Army, he chaired the Department of Community Health and Ambulatory Care at the District of Columbia General Hospital. He was promoted to Acting Commissioner for Public Health for the District of Columbia and later directed one of the busiest ambulance services in the nation.

**Christina Bethell, PhD, MBA, MPH**, is a Professor in the Department of Pediatrics at Oregon Health & Science University and the founding Director of both the Child and Adolescent Health Measurement Initiative (CAHMI) and the National Maternal and Child Health Data Resource Center. Her work to collaboratively design and validate measures of child and family health and healthcare quality has led to over 45 measures endorsed by the National Quality Forum and a range of standardized metrics used in national, state, and local surveys of families. She specializes in patient and family engagement in quality measurement and improvement.

**Kevin L. Bowman, MD, MBA, MPH**, is a Medical Director at WellPoint in the Center for Quality Measurement and Improvement (CQMI). He is responsible for improving quality of care while reducing costs for WellPoint patients. He manages, designs, and implements programs to improve patient care, reduce costs, and enhance quality performance measures. He represents WellPoint to external organizations and serves on external committees. Dr. Bowman is trained in both clinical medicine and public health, and is board certified in preventive medicine. Additionally, he served as a consultant at the National Committee for Quality Assurance where he advised and participated in various performance measurement projects.

**Debra L. Burns, MA**, has more than 20 years of experience leading public health policy, planning, and partnership development efforts. She currently directs the Office of Performance Improvement at the Minnesota Department of Health, where she is also responsible for performance management, quality improvement, community health assessment and planning, community engagement, accreditation, public health practice-based research, integrating evidence-based principles and actions into public health practice, and leading the state and local partnership. She served as Director of the Office of Public Health Practice at the Minnesota Department of Health from 2002 to 2010 and Manager of the Health Systems Development Section prior to that appointment.

**JoAnne M. Foody, MD, FACC, FAHA**, is the Medical Director of the Cardiovascular Wellness Service and Pollin Cardiovascular Wellness Program at Brigham and Women's/Faulkner Hospital. She is an Associate Professor of Medicine at Harvard Medical School and Editor in Chief of the American College of Cardiology's CardioSmart website. Dr. Foody has active national and international roles in cardiac disease prevention and rehabilitation with a particular focus on women and heart disease. Her research has focused on identifying and fostering greater use of clinical strategies that prevent adverse cardiovascular events in people with and without coronary artery disease. Dr. Foody is a Fellow of the American College of Cardiology and the American Heart Association.

**Beverly Franklin-Thompson, PharmD, MBA**, joined GlaxoSmithKline's Care Management Solutions Department in June of 2012, after 15 years in the managed care industry, most recently as Pharmacy Director for BlueCross BlueShield Tennessee where she successfully led integrated health management strategies to optimize quality related health outcomes. Having witnessed firsthand the opportunities for community health to benefit from cross collaboration during her work with Patient Centered Medical Homes and replicating the "Asheville Project" in other municipalities, Dr. Franklin-Thompson understands the need for innovation and sharing of successes as we work within our communities to develop practical solutions to improve population health.

**Reneé Frazier, MHSA, FACHE**, is an experienced leader in the healthcare management arena with expertise in hospital operations, managed care, volunteer and community service, health promotion, strategic planning, and organizational excellence. She is known for her advocacy towards greater transparency of healthcare quality indicators and patient experience report cards. She is a strong leader in the Memphis Shelby County community addressing issues of health policy, environmental barriers, health equity and community engagement which will lead our region to better population health. She currently serves on local and national committees which address quality improvement, health equity, public reporting, and consumer engagement.

**Rahul Gupta, MD, MPH, FACP**, is Health Officer and Executive Director at Kanawha-Charleston and Putnam Health Departments. He currently holds clinical faculty positions at West Virginia University School of Medicine and University of Charleston's School of Pharmacy. He also serves as medical consulting staff at Charleston Area Medical Center and volunteers clinical services at Health Right. Dr. Gupta is a nationally accomplished public health expert with extensive background in population health leadership and health policy advocacy. With more than 20 years of medical practice, population health and academic experience, Dr. Gupta serves on governing boards of several non-profit organizations including National Association of County and City Health Officials (NACCHO).

**Shelley B. Hirshberg, MA**, is the Executive Director of the P2 Collaborative of Western New York and the Project Director of the Robert Wood Johnson Foundation Aligning Forces for Quality (AF4Q) initiative in Western New York, one of 16 communities throughout the country. Previously she was President of Physician Advocates LLC, a consulting company involved with medical practices and non-profit organizations. Ms. Hirshberg created Physician Advocates LLC in 2000 and sold the business in 2006 to a local compliance professional. With more than 30 years of experience in Healthcare Administration and non-profit management, Ms. Hirshberg served as CEO of Planned Parenthood of Buffalo & Erie County and served in four different administrative roles at the Millard Fillmore Health System over a 10-year period. In addition to her professional accomplishments, Ms. Hirshberg sat on over 20 boards during the past 30 years.

**Charles J. Homer, MD, MPH**, is President and CEO of the National Initiative for Children's Healthcare Quality, an action oriented organization headquartered in Boston, MA, exclusively dedicated to improving the quality of healthcare for children. He is an Associate Professor of the Department of Society, Human Development and Health at the Harvard University School of Public Health and an Associate Clinical Professor of Pediatrics at Harvard Medical School. He was a member of the third US Preventive Services Task Force from 2000-2002 and served as Chair of the American Academy of Pediatrics Steering Committee on Quality Improvement and

Management from 2001-2004. He obtained his bachelor's degree from Yale University, his medical degree from the University of Pennsylvania, and a master's degree in public health from the University of North Carolina at Chapel Hill.

**Paul E. Jarris**, **MD, MBA,** is Executive Director of the Association of State and Territorial Health Officials (ASTHO), a national nonprofit organization that represents public health agencies of the United States, the US territories and freely associated states, and the District of Columbia, as well as the 120,000 public health professionals these agencies employ. Dr. Jarris served as Vermont's state health official from 2003 to 2006. His past leadership positions include Medical Director for Vermont's largest nonprofit HMO, President of Vermont Permanente Medical Group and CEO of Primary Care Health Partners. He is certified by the American Board of Family Medicine and is a member of the Institute of Medicine's Board on Health Sciences Policy.

**Keith C. Kosel, PhD, MHSA, MBA**, is Vice President of the Center for Applied Healthcare Studies at VHA, Inc. Dr. Kosel's responsibilities include overseeing the design, development, and implementation of qualitative and quantitative research studies involving clinical quality, patient safety, and patient experience. His work focuses on understanding knowledge transfer paradigms and how these can be used to enhance clinical quality initiatives at VHA member organizations. Dr. Kosel's prior role at VHA was as Head of the Performance Analytics Area where he was responsible for all aspects of measurement, methodology, and analytics. He has designed numerous surveys and assessment tools used to measure employee engagement, organizational preparedness, clinical performance, and patient safety. Prior to joining VHA in 2000, Dr. Kosel was Director of Clinical Programs at Blue Cross Blue Shield of Michigan, where he designed and oversaw disease management and case management programs for Ford, General Motors, and Daimler-Chrysler.

**Jeffrey Levi, PhD**, is Executive Director of Trust for America's Health, where he leads the organization's advocacy for a modernized public health system. Dr. Levi has authored reports and testified before Congress on disaster preparedness, environmental health, chronic disease, and the obesity epidemic. He is also an associate professor in the Department of Health Policy at the George Washington University School of Public Health and Health Services, where his research has focused on HIV/AIDS, Medicaid, and integrating public health with America's health care system. He served as an Associate Editor of the American Journal of Public Health and was Deputy Director of the White House Office of National AIDS Policy. He has appeared as an expert commentator on CNN, ABC, NBC, CBS, and Bloomberg TV.

**Doris Lotz, MD, MPH**, is the Chief Medical Officer for the State of New Hampshire where she provides guidance for Medicaid policies, programs, and strategic planning; oversight to quality improvement, clinical services, and managed care; and balances clinical and business priorities. Dr. Lotz advocates for quality measurement and evidence-based improvements in healthcare delivery. Dr. Lotz completed her medical degree at The Ohio State University, and residencies in Emergency Medicine at Harbor-UCLA Medical Center, and Preventive Medicine at Johns Hopkins University. She currently serves as Co-Chair of the Patient Centered Outcomes Research Institute's Improving Healthcare Systems Advisory Group and served as National Chair of the Medicaid Medical Directors Network.

**J. Lloyd Michener, MD,** is Professor and Chairman of the Department of Community and Family Medicine, and Director of the Duke Center for Community Research. Throughout his career, Dr. Michener has served as President of the Association for Prevention Teaching & Research, Chair of the Council of Academic Societies of the Association of American Medical Colleges, and a member of the Board of the Association of Academic Medical Colleges, the Association of Departments of Family Medicine, and the National Patient Safety Foundation Board of Governors. Dr. Michener is also Co-Chair of the National Institutes of Health's Community Engagement Steering Committee and a member of the Centers for Disease Control and Prevention Foundation Working Group on Public Health and Medical Education. Dr. Michener has focused on finding ways of making healthcare work better through teams, community engagement, and practice redesign. He has overseen the Obesity/Chronic Disease Prevention Programs of the Kate B. Reynolds Trust, a program designed to lower chronic disease rates in low-income areas across North Carolina, and the obesity prevention programs of the North Carolina Health and Wellness Trust Fund.

**Doriane C. Miller, MD**, is the Inaugural Director of the Center for Community Health and Vitality at the University of Chicago Medical Center. The Center for Community Health and Vitality's mission is to improve population health outcomes for residents on the South Side of Chicago through community-engaged research, demonstration, and service models. Dr. Miller joined the University in January 2009. Dr. Miller also brings over 20 years of experience as a community-based primary care provider who has worked with under-served, minority populations with a special interest in behavioral health.

**David B. Nash**, **MD, MBA**, is the Founding Dean and Professor of Health Policy at the Jefferson School of Population Health (JSPH). JSPH provides innovative educational programming designed to develop healthcare leaders for the future. Its offerings include Masters Programs in Public Health, Health Policy, Healthcare Quality and Safety, and Chronic Care Management. A board certified internist, Dr. Nash is recognized for his work in outcomes management, medical staff development and quality-of-care improvement. Currently, he is Editor-in-Chief of four major national journals.

**David Stevens, MD,** is Associate Medical Director and Director of the Quality Center at National Association of Community Health Centers (NACHC). Dr. Stevens is a clinician and medical expert on policy initiatives to foster quality improvement in areas such as chronic disease management, clinical measures, data collection, and pediatric immunizations. Dr. Stevens is also a Research Professor at The George Washington University School of Public Health and Health Services' Department of Health Policy. He served as Senior Medical Expert for Quality Improvement at the Agency for Healthcare Research and Quality (AHRQ) from 2003 until his appointment at NACHC. He was also Acting Chief of the Clinical Quality and Professional Management Branch of the Bureau of Primary Health Care (BPHC).

**Matthew Stiefel, MS, MPA**, is the Director of the Center for Population Health in Kaiser Permanente's (KP) Care Management Institute and is a faculty member for the Institute for Healthcare Improvement (IHI) Triple Aim. He joined KP in 1981 as a Medical Economist and later held management positions in the Northwest, directing planning, marketing, and medical economics. Prior to KP, he served as a Policy Analyst on the Carter Administration's Domestic Policy Staff and in the US Department of Health, Education, and Welfare. He has an

MS in epidemiology from the Harvard School of Public Health, an MPA from the Wharton School, and a BA in psychology from Stanford.

**Steven M. Teutsch, MD, MPH**, is the Chief Science Officer of the Los Angeles County Department of Public Health as of February 2009. Previously, he was Executive Director, Outcomes Research and Management Program at Merck, as well as Director of the Division of Prevention Research and Analytic Methods, and Director of the Division of Surveillance Epidemiologic Studies at the Centers for Disease Control and Prevention. He has served on the US Preventive Services Task Force, Community Guide Task Force, the Medicare Evidence Development and Coverage Advisory Committee (CMS), and on multiple Institute of Medicine committees. He has appointments at University of California, Los Angeles (UCLA) and University of Southern California (USC) and has published over 200 articles and eight books.

**Julie Trocchio, RN, MS**, is Senior Director of Community Benefit and Continuing Care at the Catholic Health Association (CHA) of the United States. She is based in CHA's Washington, DC office. Ms. Trocchio carries out programmatic and advocacy activities related to community benefit, tax exemption, environmental sustainability, and long-term care. She is also the CHA liaison to the executives of state Catholic health associations and conferences. Before joining CHA in 1988, she was Director of Delivery of Services at the American Health Care Association in Washington, DC, a nonprofit organization that represents long-term care facilities. Ms. Trocchio was also a public health nurse for the Montgomery County Health Department in Rockville, MD, and has worked as a staff nurse for a hospital and nursing home facility.