NATIONAL QUALITY FORUM

Agenda

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

Committee Web Meeting

Wednesday, March 5, 2014

12:00-2:00 pm ET

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 **100735** and click "Enter."
- In the "Display Name" field type your first and last names and click "Enter Meeting."

Teleconference

Committee Member/Speaker

- Dial **1-888-799-5160** and use confirmation code **34196143**.

Public Participant

- Dial **1-866-309-3375** and use confirmation code **34196143**.

Meeting Materials:

- Agenda
- PowerPoint
- Draft *Community Action Guide*
- Committee roster and bios

Meeting Objectives:

- Finalize the draft Community Action Guide for public comment; and
- Discuss additional questions to guide the development of the Community Action Guide.

12:00 pm **Welcome, Introductions & Meeting Objectives**

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

12:10 pm **Opening Remarks**

Nancy Wilson, AHRQ, Government Task Lead
Karen Adams, Vice President, Strategic Partnerships, NQF

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12:15 pm **Draft *Community Action Guide* Development**

Moderator: Bruce Siegel, MD, MPH (Co-Chair)

- Overview of key elements *Diane Stollenwerk, Consultant to NQF, President, StollenWerks Inc.*
- High-level reactions from committee on finalizing the Draft Guide for public comment

12:35 pm **Committee Strategic Discussion**

Moderator: Kaye Bender, PhD, RN, FAAN (Co-Chair)

- *The Appendices in the Draft Guide contain lists of measures, data sources, and tools from the Environmental Scan, along with questions for guidance from the field.*
  - *Is there a need to remove any of the items from these lists in the draft Guide before asking for public responses to the questions? If so, which items?*
- *What questions should guide feedback during the public comment period?*

1:35 pm **Shared Common Definitions for the *Action Guide***

Elisa Munthali, NQF and Matthew Stiefel, MS, MPA

- Brief committee on final definitions to be included in the Draft *Action Guide*

1:45 pm **Public Comment**

1:55 pm **Next Steps**

Elizabeth Carey, MPP, Project Manager, Strategic Partnerships, NQF

2:00 pm **Adjourn**

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

NATIONAL QUALITY FORUM

Committee Web Meeting
March 5, 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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Agenda at a Glance

- Welcome and Introductions
- Opening Remarks
- Draft Community Action Guide Development
- Committee Member Strategic Discussion
- Shared Common Definitions for Draft Action Guide
- Public Comment
- Next Steps

Meeting Objectives

- Establish agreement on Community Action Guide key elements
- Discuss additional questions to guide the development of the Community Action Guide.

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

Beth Carey, MPP

Project Manager, Strategic Partnerships

Zehra Shahab, MPH

Project Analyst, Performance Measurement

Danitza Valdivia

Administrative Manager, Strategic Partnerships

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Opening Remarks

Nancy Wilson, MD, Government Task Lead, AHRQ

Karen Adams, PhD, Vice President, Strategic Partnerships, NQF

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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**.

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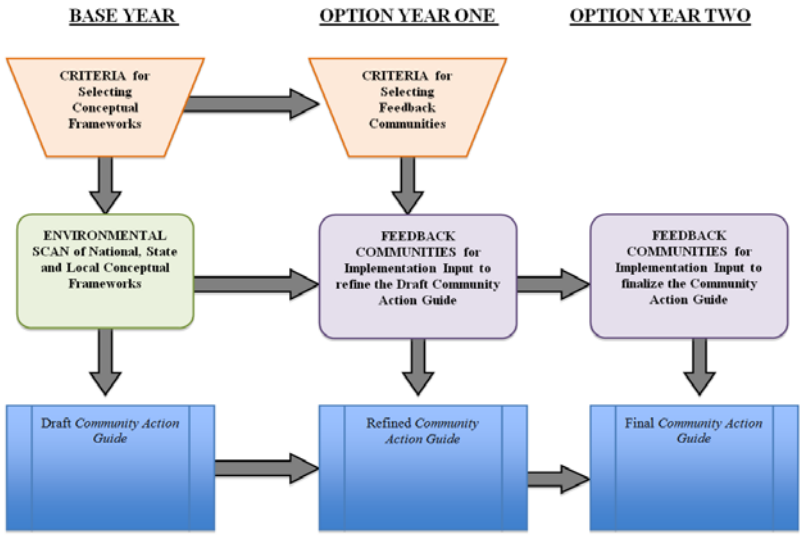
Starting with the End in Mind: Connections across Project Deliverables



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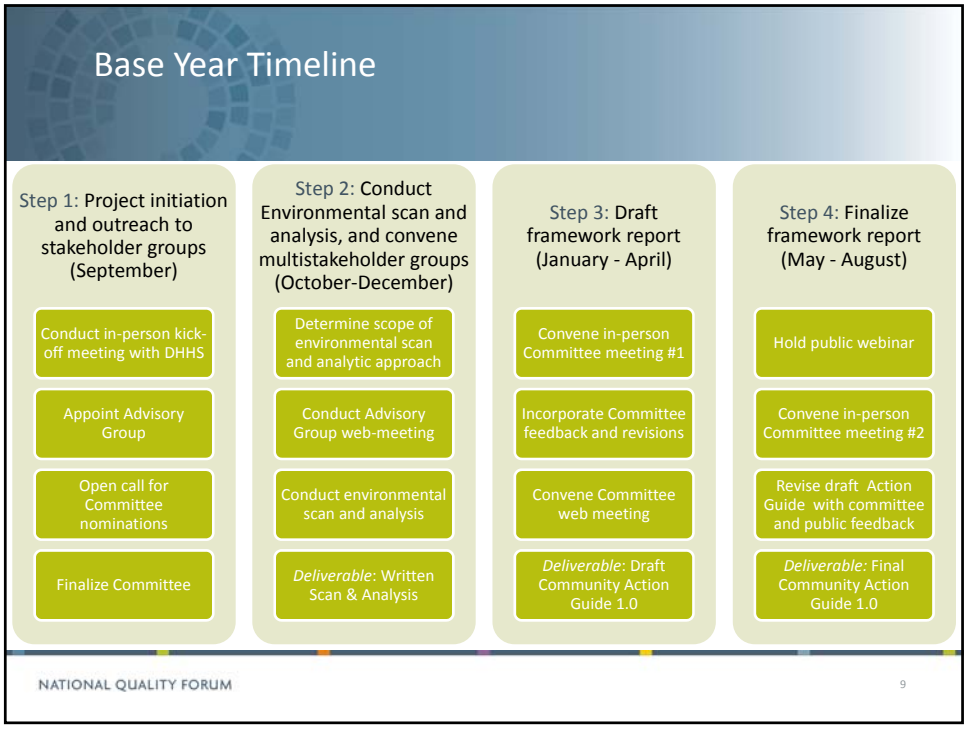
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Step 1: Project initiation and outreach to stakeholder groups (September)
Conduct in-person kick-off meeting with DHHS
Appoint Advisory Group
Open call for Committee nominations
Finalize Committee
Step 2: Conduct Environmental scan and analysis, and convene multistakeholder groups (October-December)
Determine scope of environmental scan and analytic approach
Conduct Advisory Group web-meeting
Conduct environmental scan and analysis
Deliverable: Written Scan & Analysis
Step 3: Draft framework report (January - April)
Convene in-person Committee meeting #1
Incorporate Committee feedback and revisions
Convene Committee web meeting
Deliverable: Draft Community Action Guide 1.0
Step 4: Finalize framework report (May - August)
Hold public webinar
Convene in-person Committee meeting #2
Revise draft Action Guide with committee and public feedback
Deliverable: Final Community Action Guide 1.0
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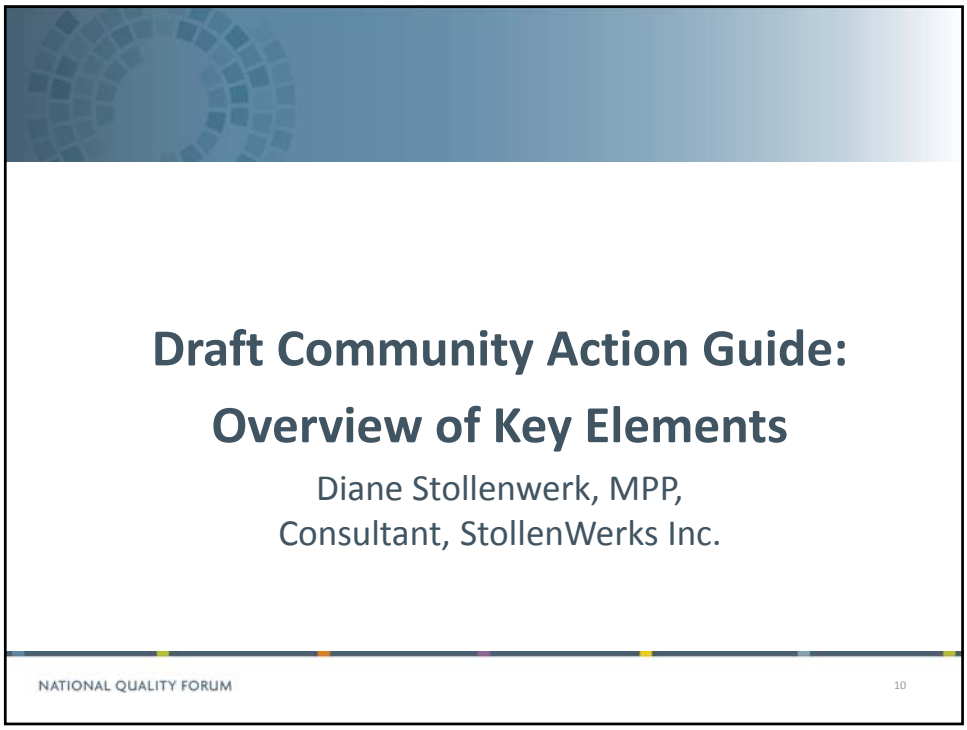
Draft Community Action Guide:
Overview of Key Elements
Diane Stollenwerk, MPP,
Consultant, StollenWerks Inc.
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Draft Community Action Guide Development

- Iterative process
  - Built on prior work from Jacobson and Teutsch commissioned by NQF [1]
  - Informed by an environmental scan of frameworks conducted for this project [2]
  - Incorporated multistakeholder committee input
- Synthesized findings into ten key elements

[1] Jacobson, DM and 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.

[2] 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*. 2013. Available at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=74400

Ten Key Elements

1. A self-assessment about readiness to engage in this work
2. Leadership across the region and within organizations
3. An organizational planning and priority-setting process
4. A community health needs assessment and asset mapping process
5. An agreed-upon, prioritized set of health improvement activities
6. Selection and use of measures and performance targets
7. Audience-specific strategic communication
8. Joint reporting on progress toward achieving intended results
9. Indications of scalability
10. A plan for sustainability

Key Element #1

A self-assessment about readiness to engage in this work

- Review the current state of the elements 2-10
- Consider using other existing self-assessments
- Determine the starting point, which may differ depending on the findings of the self-assessment
  - For example, preliminary asset mapping may identify existing efforts to improve population health that can be strengthened, rather than starting from scratch

Key Element #2

Leadership across the region and within organizations

- Requires skills in
  - Relationships and roles management
  - Strategy
  - Being a neutral convener to build bridges – “a trusted broker”
  - Finding the right people
- Draws on adaptability, resilience, and change management
- Takes place across a continuum, within
  - the group of organizations
  - a single organization
  - among individuals and groups in the region

Key Element #3

An organizational planning and priority-setting process

- Aim for transparency and equity in decision-making
- Set a clear method for
  - Identifying the right interventions
  - Learning from experience
  - Monitoring ongoing feedback loops
- Develop the evaluation approach from the start to assess the success of the overall initiative and the desired health impact
  - Evaluation will provide insight for a number of the recommended elements

Key Element #4

A community health needs assessment and asset mapping process

- Align selected priority areas for population health improvement with actual needs and available resources
  - Many organizations already engaged in needs assessments due to ACA and 501c3 requirements
- Listen and learn about what is already in place in the region and what can be leveraged
- Collaborate on the needs assessments and asset mapping to reduce duplication, improve coordination, and accuracy

Key Element #5

An agreed-upon, prioritized set of health improvement activities

- Draw insights from health needs assessment and asset mapping process
  - Consider contributing factors and root causes to identify potential solutions
- Take responsibility for leading one (or a small number) of health improvement areas
- Identify clear roles for participating organizations and individuals

Key Element #6

Selection and use of measures and performance targets

- Identify an ideal menu of measures with phased implementation
  - Consider available data sources to set performance targets and assess progress
- Include disparities-sensitive measures where available
- Take a pragmatic approach
  - Recognize what is available, what is understandable, where more work or progress is needed

Key Element #7

Audience-specific strategic communication

- Recognize and adapt to differences across audiences
  - Use culturally sensitive communication ("cultural humility")
  - Make the business case (e.g., value-proposition, return-on-investment)
  - Speak to social values (e.g., equity and fairness)

Key Element #8

Joint reporting on progress toward achieving intended results

- Aspire to ultimately share the results with the entire community
- Report on several areas such as
  - Measurement results
  - Progress toward performance targets
  - Social values
  - Return on investment
  - Impact of overall initiative

Key Element #9

Indications of scalability

- Identify and emphasize activities that can be expanded or adopted by others
  - Can mean becoming deeper within a region or spreading to other communities
- Consider which assets may be unique to a particular setting or group

Key Element #10

A plan for sustainability

- Foster adaptability and resilience
- Capitalize on opportunities from new public and private policy approaches
  - Information technology infrastructure
  - Relationship connections (e.g., ACOs, PCMH, ACHs)
  - Payment arrangements
- Encourage supportive public or private policy changes
  - Might, but does not always, involve political advocacy

Committee General Reactions

Moderator: Bruce Siegel

Discussion Questions

Committee Reactions on Finalizing this Draft for Public Comment

- Are there any "red flags" before we post this draft for the Public Comment Period?

Committee Strategic Discussion

Moderator: Kaye Bender

Data Sources, Measures and Tools

Illustrative Examples and Lists in the Appendices

- Reminder of Environmental Scan finding: *Abundance of measure domains, measures, and data sources can be counter productive*
  - There are many options from which to choose; examples and links in the draft Guide are illustrative
- Each appendix lists the frameworks or initiatives from the Environmental Scan that include measures, data sources or tools
  - To apply a practical implementation lens to narrow the lists, each appendix starts with questions to gather input from the field regarding which items are most useful
  - Eventually, each list will be honed as *a suggested place to start, consistent with the action-oriented nature of the Guide*

Discussion Questions

Appendices Content: Measures, Data Sources, and Tools

- Lists in the Draft Guide with questions for guidance from the field
  - Appendix B: Sources of Measure Sets from the Environmental Scan
  - Appendix B: Sources of Data from the Environmental Scan
  - Appendix C: Sources for Tools and Other Resources from the Environmental Scan
- Is there a need to remove any of the items from these lists in the draft Guide before asking for public responses to the questions?
  - If so, which items should be removed?

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Discussion Questions

Public Comment Feedback

- What questions should guide feedback during the public comment period?
- Examples:
  - Is this Guide easy to understand? What would make it better?
  - Are the examples helpful?
  - Are the linked measures, data and tools ones that you find useful?
  - What other changes are needed? What is missing?

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Shared Common Definitions for the *Action Guide*

Matthew Stiefel, MS, MPA

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

Foundational Work on Definitions

- Foundational work led by Jacobson and Teutsch aimed to provide an integrated set of definitions for population health, the determinants of health, and health improvement activities (as well as measurement framework, and shared set of indicators).
  - Scan did not find a central authoritative source for defining population health or the determinants of health, but ultimately
- With significant input from multistakeholder committee, Jacobson and Teutsch recommended:
  - Adoption of WHO definition of health;
  - Use of "*Total Population"* instead of *"Population"* – individuals in a specified geopolitical area;
  - Use of "*Sub-population"* – systems within systems approach in the context of *Total Population*; and
  - General term such as "*Health Improvement Activities"* should be used when describing activities across the prevention-diagnosis- treatment continuum that occurs within the clinical care system and public health system.
- Prior work helped to inform current discussion

Definitions for the Action Guide

1. **Population** (also referred to as **Total Population**) – All individuals in a specified geopolitical area
2. **Sub-population** – A group of individuals that are a smaller part of a population. Sub-populations can be defined by geographic proximity, age, race, ethnicity, occupations, schools, health conditions, common interests, or any of a number of other characteristics
3. **Health** - a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity
4. **Population Health** – The health of a population, including the distribution of health outcomes and disparities in the population

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Definitions for the Action Guide

5. **Determinants of Health** – Factors affecting the health of individuals in a population or sub-population, such as the social and physical environment, behaviors, and health care.
6. **Disparities** – Differences in health status or health outcomes within a population, or differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention

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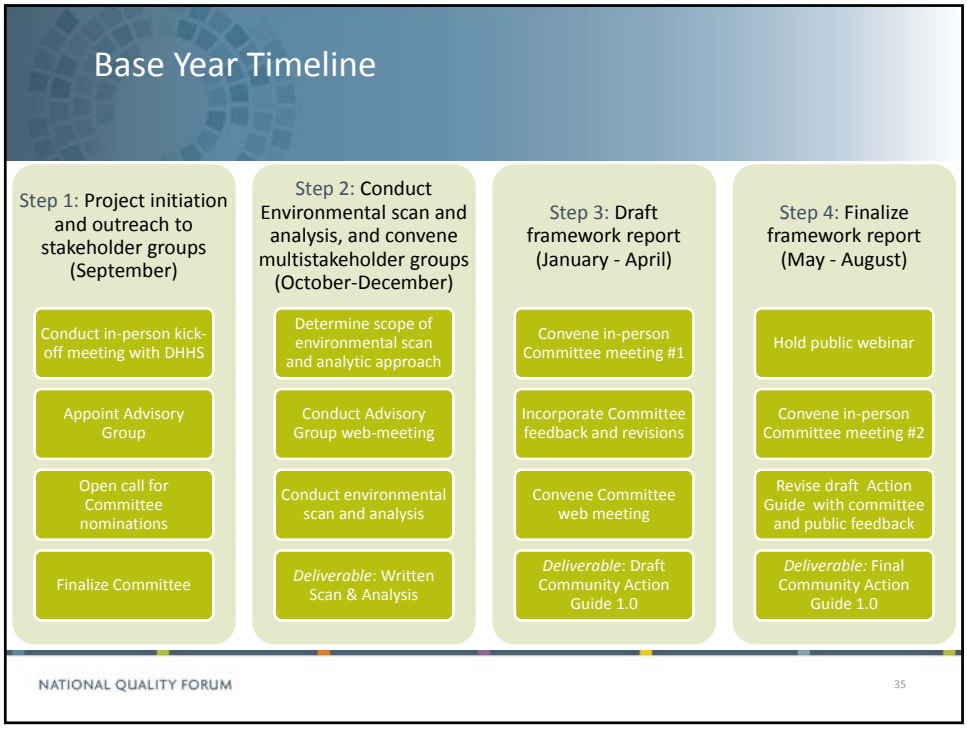
Public Comment

Next Steps

Beth Carey, MPP, Project Manager, Strategic Partnerships, NQF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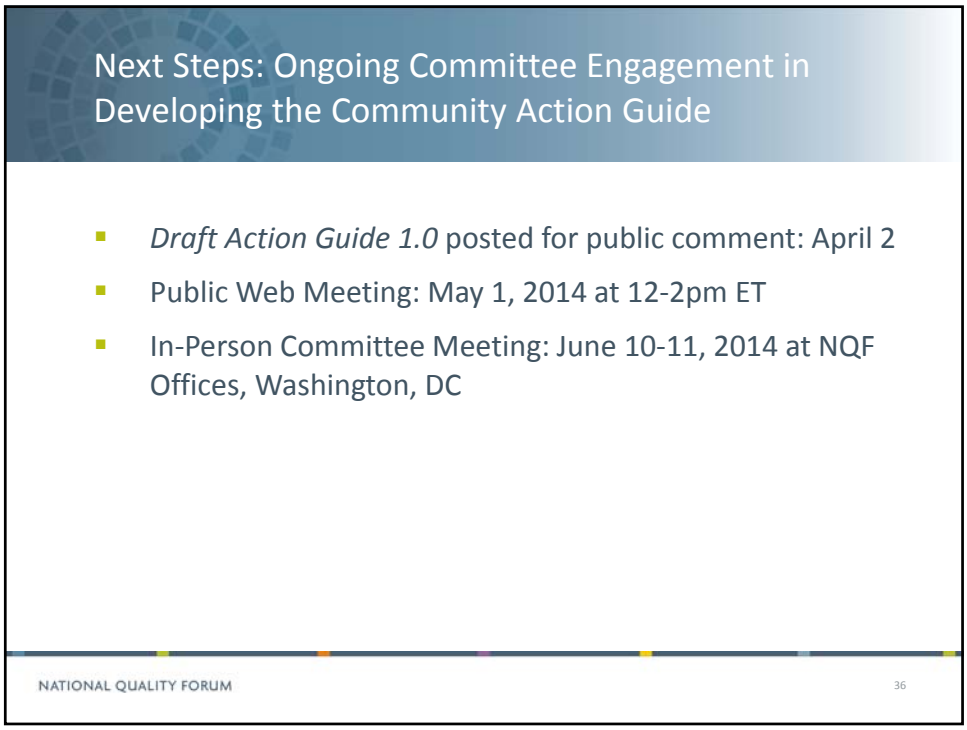
Next Steps: Ongoing Committee Engagement in Developing the Community Action Guide
Draft Action Guide 1.0 posted for public comment: April 2
Public Web Meeting: May 1, 2014 at 12-2pm ET
In-Person Committee Meeting: June 10-11, 2014 at NQF Offices, Washington, DC
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NATIONAL QUALITY FORUM

Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities -- Action Guide 1.0 - DRAFT

February 26, 2014

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

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Why Focus on Improving Population Health?

Unsustainable cost, poor health status and significant disparities in health care are well known. Improving the health within and across populations is an important part of the solution. You are reading this Guide likely because you have an interest in this issue. Whether you are an individual wanting to make a difference in the health of people in your neighborhood or at your workplace, a doctor or nurse working closely with patients to improve their health, a public health professional or other leader in just about any type of organization – this Guide is meant for you.

Yet, the health of the total population cannot be improved by one person or organization alone, or solely by public health agencies, or even by the vast health care sector. The reality is that many factors influence health and need to be addressed in a coordinated way by a range of individuals and organizations that include patients, community members, policy makers, health care providers, and other leaders from business, public health, and insurers, among others. This Guide can help you create a path forward to engage with others in organizations you are involved in, and expand to work with even more groups to increase the likelihood of success in improving population health.

Many people think of health care when talking about how to improve health; however, medical care has a relatively small influence on overall health when compared with individual behavior, the physical environment such as safe neighborhoods and housing, and social factors including high school graduation rates and poverty.[1] Because the issues are wide ranging and the pressure to improve health and reduce health care costs is tremendous, population health improvement can seem too big a challenge for people in any one sector, organization or individual to take on and have an impact. The only way to improve population health is to coordinate efforts.

Beyond health care and public health, the concept of 'health in all policies' suggests that even those who may not think of their work as being about health – such as housing organizations, employers, schools, jails, transit systems, land development, and the like –make decisions and create environments that can help or hinder good health. Perspectives regarding the role of health improvement for certain sectors are described below, but individuals in every organization have a role in helping to improve health for the people in the subpopulations they affect or influence.

- **Health care providers** have a particular responsibly to improve the health care outcomes for the people under their care, and for society at large. This requires taking clear responsibility for promoting and improving the health of patients, in addition to caring for them when they are injured or sick. Making this shift is almost counter-cultural for the health care system, as American society tends to value personal independence and responsibility, and can be skeptical about coordinated efforts involving public and private organizations.[2] But the pressure to move in this direction is increasing.

- **Public health professionals** have focused on population health improvement for many years at the tribal, local, state and territorial levels. In the public health system, there are different levels of

[1] E. Eggleston, MD MPH and J. Finkelstein, MD MPH. Finding the Role of Health Care in Population Health. American Medical Association 2014. http://jama.jamanetwork.com doi: 10.1001/jama.2014.163
[2] Ibid.

capacities and resources, skill sets, and coordination with partner organizations. The increase in accreditation for public health agencies is an important development to advance the effectiveness of public health agencies in fulfilling their mission. Of the 11 areas in which accredited public health agencies are held accountable, four of them go right to the heart of population health improvement: monitor health status and understand health issues; protect people from health problems and health hazards; give people information they need to make healthy choices; and, engage the community to identify and solve health problems.[3]

- **Business leaders and purchasers in the public and private sectors** deal every day with the direct and indirect impact of poor health of their employees and family members, and the population overall. This appears as higher health care costs; for example, according to the Centers for Disease Control and Prevention, chronic disease such as heart disease, stroke, and diabetes accounts for 75 percent of the $2 trillion spent on medical care. In addition, the CDC estimates that the indirect cost of employee absenteeism, turnover, short-term disability, workers compensation and reduced work output may be several times higher than direct medical costs. These costs affect all employers, even those who choose not to help pay for health insurance for their employees.

The cost of poor health is staggering and the evidence is clear that improving health saves money. A few examples:

- Investing in "community building" – such as economic and workforce development, leadership training, environmental improvements, housing, among others – is an effective strategy for improving population health, and there is a financial return on investment. For example, a tobacco cessation program created by the State of Massachusetts yielded a savings of $571 in avoided hospital costs per participant, after spending $183 per person in the program. In other words, for every $1 spent, $3.12 was saved in avoided medical costs. For the Medicaid program, there was a savings of $2.12 for every dollar spent.[4]

- In Camden, NJ, leaders recognized that a small number of people who frequently used hospital services were generating about 90 percent of the hospital costs. One patient had come to the emergency department 113 times in a single year. Health care providers alone could not solve this problem. However, by taking a community-based team approach to addressing the social and personal needs of these patients – including housing, food, home visits and social contact – they were able to stabilize the health of this subpopulation and head off medical issues that could cost millions of dollars to address. Their coordinated efforts resulted in a 40 percent reduction in emergency department visits and a 50 percent decrease in hospital costs.[5]

- The chart below is a clear example of the greater effect that population health improvement can have on real people. Within a population of 100,000 people ages 30-84, if everyone followed basic

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[3] Final Recommendations for a Voluntary National Accreditation Program for State and Local Public Health Departments. APHA, ASTHO, NACCHO, NALBOH. September 2006. http://www.phaboard.org/wp-content/uploads/ExploringAccreditationFinalRecommendations.pdf

[4] A Compendium of Proven Community Based Prevention Programs, NY Academy of Medicine and the Trust for America's Health, 2013. http://healthyamericans.org/assets/files/Compendium_Report_1016_1131.pdf

[5] Robert Wood Johnson Foundation, *Building a Culture of Health: 2014 President's Message*. http://www.rwjf.org/en/about-rwjf/annual-reports/presidents-message-2014.html

guidelines for good health, far more deaths would be prevented or postponed when compared to the impact of consistently and appropriately using key heart-related medical interventions.[6]

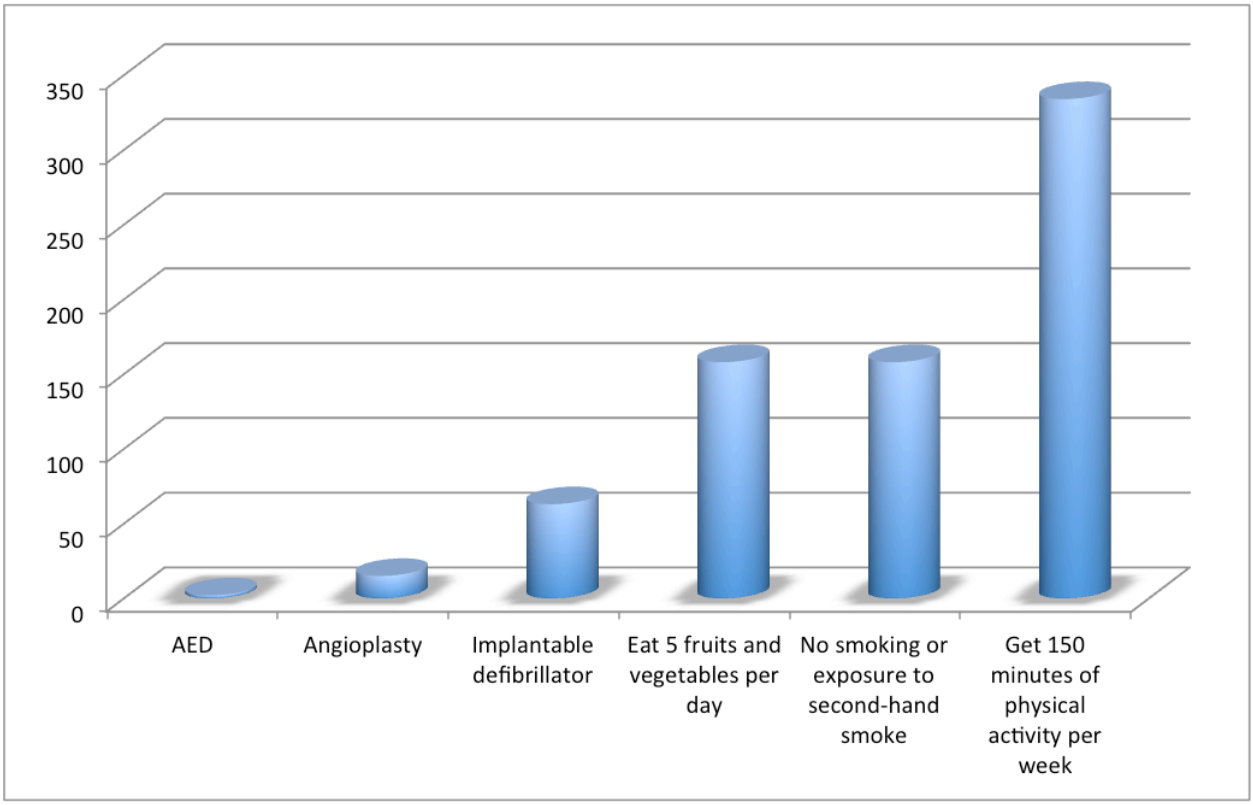

Figure 1 More Deaths Can be Postponed or Prevented by Meeting Good Health Guidelines, Compared to Consistently and Appropriately Using Heart-Related Medical Services[7]

A death prevented or postponed avoids the direct and indirect costs of illness and disease caused by poor health. Heart disease and death caused by smoking or obesity, for example, doesn't happen quickly: the years of poor health result in much higher medical costs, plus the cost of absenteeism and reduced productivity at work.

Above all, improving population health is about making life better for real people: our family members, co-workers, neighbors and ourselves. Preventing and postponing death saves lives and increases the odds that every person has the opportunity to live a long and healthy life.

Pieces of the "population health improvement" puzzle are being developed and, in some areas, coming together to create a more complete and effective effort. For example, establishing Accountable Care Organizations that align goals and perspectives across certain health care organizations is one aspect but not the same as a comprehensive effort to improve population health. Creating clear incentives is certainly an essential part of the big picture to improve population health. This is taking place in

[6] T. Kottke MD MSPH, and N. Pronk PhD, "Creating Health: Finding the Path from Here to There" Population Health Sciences, January 2013. http://www.improvingpopulationhealth.org/blog/2013/01/creating-health-finding-the-path-from-here-to-there.html

[7] Ibid.

programs such as Medicare Shared Savings, the IRS community benefit rules for non-profit hospitals, public health accreditation, and the growing use of health impact statements as part of public policy decision-making. However, more work is needed, as certain pieces of the overall puzzle to achieve better population health at the local, state and national levels are still missing or hard to find.

Even with a shared commitment to improving population health, this is challenging work. No person or organization can improve population health alone, so coordinated collaboration is essential. However, different people and groups may be motived by competing incentives and interests that are not aligned. Capturing and sharing information is often difficult, not only because the technology involved may not be available or interconnected, but also because of differences in definitions, cultures, viewpoints, regulations, and available resources.[8]

This Guide is intended to help light a path forward for any person in any organization to begin to address these issues. It's time for everyone to get more involved.

What is this Guide?

This Guide, tentatively called the *Guide for Community Action* (or *Guide*), is a handbook to be used by individuals in any type of group who want to improve health across a population, whether in a local, state or national region. It contains brief summaries of ten useful elements important to consider during efforts to work with others to improve population health, along with suggested actions to take and links to examples of practical resources available for your use.

There are many reports, websites, tools and other resources for every aspect of population health improvement. While each item may be very helpful, the sheer volume can be overwhelming. This Guide is intentionally short, with links to more information and resources. It takes a broad look at the issue, without duplicating the great work already done by others.

As an essential forum for catalyzing improvements in health and healthcare, the National Quality Forum (NQF), with funding from the Department of Health and Human Services, is convening a multistakeholder committee to develop this Guide through a transparent and iterative process. The Population Health Framework Committee represents diverse expertise in the areas of population and community health, public health, healthcare, home- and community-based services, consumer advocates, and others who influence population health. (See Appendix E for the Committee Roster.) The committee membership and process represents on a micro-level the multi-disciplinary, collaborative nature of population health improvement.

The Guide's purpose is to support individuals and groups working together within a region and at all levels – community, state and national – to successfully promote and improve population health over time. This is not about starting a program with a short-term goal that, when reached, one can declare success, shut down the project and go back to business as usual. This Guide encourages thinking of

[8] E. Eggleston, MD MPH and J. Finkelstein, MD MPH. Finding the Role of Health Care in Population Health. American Medical Association 2014. http://jama.jamanetwork.com doi: 10.1001/jama.2014.163

population health improvement work as: a long-term initiative or approach involving many types of organizations and groups across a region and at multiple levels; and, a team effort in which people take on specific types of actions that, in some cases, fundamentally change how things are done. In other words, this Guide describes what it takes to make lasting improvements in population health.

The content in this Guide is based on research and information from expert guidance about what works to improve population health. This first version of the Guide – version 1.0 – includes questions, because more understanding is needed about certain topics. For example:

- The key elements listed in this Guide are based on lessons from research and analyses, plus expert opinion. The ten elements are ready for attention and comment, and practical testing by groups who are directly involved in population health improvement.

- The sources for measures, data, and resources and tools listed in this Guide were identified through an environmental scan and suggestions from experts. With reactions and ideas from groups who are working to improve population health in the field, these lists will be refined to focus on the items which are most useful and helpful.

- Similarly, the practical suggestions and input about the sources of measures, data, and resources and tools will inform national and state partners regarding ways in which these items can be improved or expanded to be more useful for population health improvement.

Based on the answers to questions and comments offered by people who read and who use this first version of the Guide, it will be updated.

How to Use the Guide

Anyone interested in improving population health can use this Guide to make progress. Like a handbook or "how-to" manual, the Guide suggests ten useful steps toward building or refining initiatives to improve population health.

Standard Steps, Custom Approaches. While the ten elements presented in this guide are based on evidence and expert opinion, the exact path forward to improve population health depends on the situation where the work is being done. Many different types of organizations and people, personal decisions, and social and environmental situations influence the health of individuals, sub-populations and populations. The mix and degree of impact from these influential factors, or determinants of health, differs by location.

People focused on any type of population in an area – whether a small neighborhood or nationwide or anything in between – can use this Guide. How the insights from this Guide are applied for a given region will undoubtedly differ to fit the specific circumstances. What a tribe in rural New Mexico may need to do with its employer and community partners will not be the same as the particular actions of a statewide coalition of many different types of organizations in Georgia. Nor will it mirror decisions made by hospitals working with public agencies in Delaware, Maryland and Virginia to improve population health across the area called Delmarva.

Start Where You Are. Whether refining efforts that have been going on for years or starting a new venture, this Guide can help. In some regions, there are long standing programs to improve population health. This Guide can be used to assess and further refine or expand such work. In other regions, bringing organizations together to improve population health may be new, so this Guide offers a road map to move forward. Ideas for using this Guide include:

- ✓ **Prepare to get started**: Drive initial thinking about the current situation in your region and what likely needs to be done to succeed.
- ✓ **Bring others on board**: Share the insights you gain and encourage others to come to the table and participate in the initiative.
- ✓ **Take a deeper dive**: Use the description of each of the ten elements for a general overview, then follow the hyperlinks under the examples and resources to dig deeper, explore options and find what is most useful to your region.
- ✓ **Stay on course**: Post or distribute the handy checklist on page 11 as a quick reminder of the ten elements that are important to success.

Important Words with Clear Definitions

It's no surprise that there are differences in the words people use to describe this work, given the many types of organizations and individuals involved in some aspect of population health. Clear communication is critical to working well together, not only to avoid misunderstanding but also to keep everyone focused on the shared goal.

While many words or terms associated with population health may come up in discussions, the terms listed below are among the most important for establishing a common understanding among different groups. The purpose of using one set of terms and definitions is to reduce confusion because of different meanings for the same word, or different words used to mean the same thing.

1. **Population Health --** The health of a population, including the distribution of health outcomes and disparities in the population. [9]
2. **Population (also, Total Population) --** All individuals in a specified geopolitical area. [10]
3. **Sub-Population --** A group of individuals that are a smaller part of a population. Sub-populations can be defined by geographic proximity, age, race, ethnicity, occupations, schools, health conditions, interests, or any of a number of other shared characteristics.[11]

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[9] Adapted from the definition of Population Health in David Kindig and Greg Stoddart. What Is Population Health? *American Journal of Public Health,* March 2003: Vol. 93, No. 3, pp. 380-383.

[10] Adapted from Recommendation #1 in: Jacobson, DM and 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.

4. **Health --** A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[12]

5. **Determinants of Health --** Factors affecting the health of individuals in a population or sub-population, such as the social and physical environment, behaviors, and health care. [13]

6. **Disparities --** Differences in health status or health outcomes within a population, or differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention. [14]

These short definitions are intended to be useful for everyone involved in the population health improvement work to "get on the same page" and avoid the pitfalls of miscommunication.

When thinking about these terms and discussing them with others, there are a number of important concepts to keep in mind. For example, the definition of population that we are using in this Guide includes everyone in a geopolitical area in order to promote focus on improving the health of all individuals in a region regardless of other characteristics. Geopolitical areas or regions can be determined by zip code, precinct, ward, county, district, metropolitan statistical area, state, multi-state region, nation, continent, or worldwide. In contrast, a geographic area might be less precise – such as along the coast, or west of the mountains – and therefore may prove difficult in unexpected ways. Using boundaries that coincide with geopolitical designations may increase chances of finding useful data sources, as most publications that assess population health use population-based surveys that pull information across a region that has political and geographic significance.[15] Program funding and government regulation are often based on or defined within a geopolitical boundary, as well.

Sub-populations can be any type of group with shared characteristics, such as race, ethnicity, a group of employees, students at a particular school or education system, a medical condition, and so on. This can also include people in a group that might be relatively rare – such as people with "orphan conditions", or transgender people – or be a defined group in a large geopolitical area, especially because of the way technology and social networks enable people with shared characteristics to connect.

Using the definition of sub-population is important when setting goals and objectives for health improvement activities implemented by clinical care systems, government public health agencies, and

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[11] Drawn from the definition of "community" in *Public Health: What It Is and How It Works. Fourth Edition.* Boston: Jones and Bartlett, 2009.
[12] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946.
[13] World Health Organization, retrieved 2014: http://www.who.int/hia/evidence/doh/en/
[14] Institute of Medicine (IOM), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Washington, DC: National Academies Press; 2002.
[15] Adapted from Recommendation #1 in: Jacobson, DM and 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.

multi-sectoral partnerships and collaborations.[16] It allows a "system within systems" approach where each of these sectors or organizations can work with its service sub-population (e.g., covered members, hospital referral area, or an at-risk sub-population) in the context of a total population within a geopolitical area. This approach also accommodates the separate funding, implementation expectations, and data collection systems (often stand-alone) of the various sectors or groups.[17]

The term "community" is often used interchangeably with "population" or "sub-population"; however, that can lead to misunderstandings because there are so many possible meanings of 'community.' To avoid confusion, this Guide refers to populations or sub-populations rather than communities.

The definition of health used here encompasses a complete state of wellness. The World Health Organization established this broader definition and has used it consistently since 1948. Understanding population health also requires noting the variation in health within sub-populations of people in the total population. It includes looking at patterns of health determinants, and the policies and interventions that link health determinants with health outcomes, both within and across the population.

Whether people are healthy or not is determined both by individual biology, the environment, and the combination of the two. Factors such as where we live, the state of our environment, genetics, income and education level, and relationships with friends and family have a considerable impact on health. These determinants combine to affect the health of individuals, sub-populations and the total population. While access and use of health care services may be more commonly considered when thinking about health improvement, health care has less of an impact on population health when compared to other factors such as the social and economic environment; the physical environment; and, the person's individual behaviors.

Disparities in health usually refer to differences in health status or health outcomes when comparing groups within a subpopulation or the population overall. Groups that are most often considered when addressing disparities are defined by race or ethnicity, such as Blacks /African-Americans, Hispanics/ Latinos, Asian /Pacific Islanders, and Native Americans /Alaska Natives, in addition to persons with Limited English Proficiency (LEP). This is an important first step; however, disparities should be assessed for all vulnerable groups—including people who are disabled, pregnant women, children, the elderly, and lesbian /gay /bisexual /transgender (LGBT) individuals.[18]

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[16] Adapted from Recommendation #2 in: Jacobson, DM and 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.

[17] Ibid.

[18] Drawn from National Quality Forum (NQF), *Commissioned Paper: Health Care Disparities Measurement*, Weissman et al, 2012. Available at https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=67965

Quick View: Action Guide Key Elements

Ten elements are important to successful approaches to improving population health. Use this checklist as a quick reference for starting a new project or refining or coordinating programs already in place.

Ten Key Elements for Improving Population Health

1. A self-assessment about readiness to engage in this work
2. Leadership across the region and within organizations
3. An organizational planning and priority-setting process
4. A community health needs assessment and asset mapping process
5. An agreed-upon, prioritized set of health improvement activities
6. Selection and use of measures and performance targets
7. Audience-specific strategic communication
8. Joint reporting on progress toward achieving intended results
9. Indications of scalability
10. A plan for sustainability

For more information, see the full *Action Guide v1.0.* For each element above, the Guide describes what it is, why it is important, gives examples of how it can be done, and provides links to useful resources.

Ten Key Elements: Overview

A variety of factors are important for creating and sustaining successful approaches to improving population health. The ten elements in this Guide were identified based on research and assessments of existing initiatives to improve population health. Many promising programs already include some or most of these elements. To improve the likelihood of long-term success, all ten of the elements should be addressed when starting a new project or when refining or coordinating programs already in place.

Each section below describes what the element is, why it is important, gives examples of how it can be done, and provides links to useful resources. While the elements are presented in a numbered list, the order in which they are addressed may differ, especially after completing the self-assessment.

Element 1: Self-Assessment of Readiness to Engage in this Work

What it is.

The self-assessment is an internal or personal review of the current situation in a region, using the Elements 1 to 9, listed in this Guide, as the focus. The results of the self-assessment can identify strengths and weaknesses in current activities, approaches or plans for improving population health. The assessment can also highlight assets or capabilities, and reveal gaps or areas where there is a need for more resources or improvement. In addition to the ten elements listed in this Guide, other organizational self-assessment tools, such as those listed under **Links to Resources** below, can be useful too.

Why it is important.

Like a carpenter who first checks if he has the right tools and skills to take on a new project, or an athlete who assesses her strengths and weaknesses to develop an effective training program, a self-assessment creates a foundation for understanding the current situation and environment. Results of a self-assessment are important for making informed decisions when identifying key groups to participate in the work, setting goals and objectives, developing strategies, creating plans, then taking steps to move forward to achieve the desired results.

Depending on the insights from the self-assessment, the logical order of next steps may differ. For example, if the assessment indicates that there has been little or no collaborative work in a region to improve health within or across the population, the first step might be to identify and bring together a small group of interested leaders to explore how to get started. In contrast, a self-assessment that reveals a number of existing population health improvement projects or activities in a region may indicate the need to bring together the natural leaders and identify where new or stronger connections may be needed. It could also inform decisions about which organizations appear to be well positioned to actively participate in a multi-stakeholder effort in the region.

How it can be done.

Such a self-assessment can be done informally as an initial individual review. It can also be done using a more structured and resource-intensive approach, which might involve research, surveys of key organizational partners or other stakeholders, informational interviews, and other ways to gather information. Just as there is no one correct way to approach the self-assessment, the questions to explore may differ by region. The questions may also differ depending on whether this is the first or the fifteenth time a self-assessment is being done.

For each of the ten elements in this Guide, any number of questions might be explored during a self-assessment. The questions below are examples that can help kick-start the process.

1. **A self-assessment about readiness to engage in this work**: *What types of assessments have already been done in efforts to improve the health of this population?*

2. **Leadership across the region and within organizations**: *Which individuals or organizations in the region are recognized or potential leaders in population health improvement?*

3. **An organizational planning and priority-setting process**: *Which organizations in the region engage in collaborative planning and priority setting to guide activities to improve health in the region?*

4. **A community health needs assessment and asset mapping process**: *Which organizations in the region already conduct community health needs assessments or asset mapping regarding population health?*

5. **An agreed-upon, prioritized set of health improvement activities**: *What are the focus areas of existing population health improvement projects or programs, if any?*

6. **Selection and use of measures and performance targets**: *Which measures, metrics or indicators are already being used to assess population health in the region, if any?*

7. **Audience-specific strategic communication**: *What is the level of skill or capability to engage in effective communication with each of the key audiences in the region?*

8. **Joint reporting on progress toward achieving intended results**: *Which organizations in the region publicly or privately report on progress in improving population health?*

9. **Indications of scalability**: *For current or new population health work in the region, what is the potential for expansion into additional groups or other regions?*

10. **A plan for sustainability**: *What new policy directions, structural changes, or specific resources in the region may be useful for sustaining population health improvement efforts over time?*

After the self- assessment is done, the findings should be helpful to identify the next steps to take. For example, the self-assessment may indicate that it is not clear what is already happening in the region, so a basic mapping of assets would be helpful to identify existing population health improvement activities along with organizations or individuals who might be great potential partners. The results of the asset

mapping could inform whether to start a new approach or, instead, focus on expanding or connecting existing activities.

The ten elements do not need to be followed in numeric order, starting from Element 1 (self-assessment) and ending with Element 10 (sustainability). The elements should be addressed in any order based on the regional situation. Some elements, such as leadership and strategic communication, will continue to be important throughout the process, with constant updates to adapt to the changing situation.

The simple chart below offers just one example. Under step one shown in the blue column, a self-assessment (Element 1) is done. If this shows that there is a lack of information about health improvement activities in a region, during step two in the purple column, it may be useful to identify or map the assets in the region (Element 4) with a focus on identifying organizations already involved in improving population (or sub-population) health. This could help identify others who then are invited to the table, using leadership skills (Element 2) and audience-specific communication (Element 7). Then, in step three in the green column, an expanded group of committed participants defines the organizational planning and priority setting process (Element 3) and completes a broader community health needs assessment and asset mapping process (Element 4) while continuing to apply effective leadership and communication skills along the way.

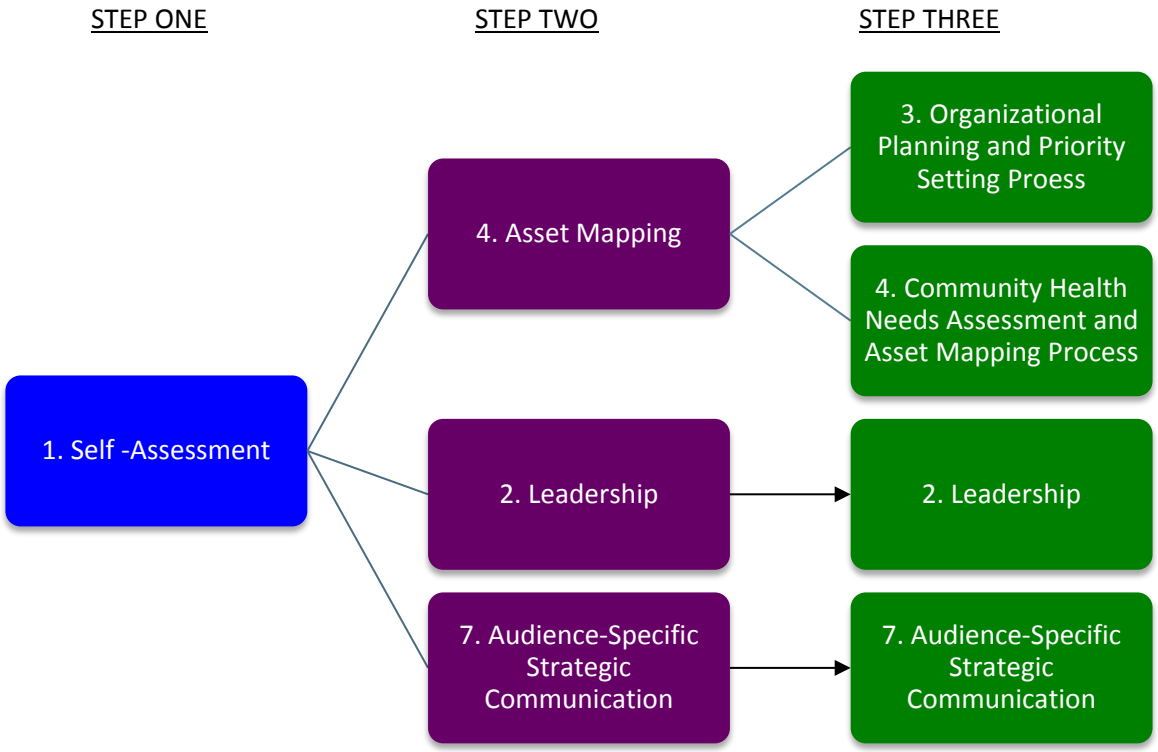

Figure 2: Illustration of How Applying the Ten Elements Doesn't Always Happen in Numeric Order

Links to Resources.

Listed below are links to more information, tools and other resources about this topic.

- **Community Health Ranking and Roadmaps – Tools and Resources:** This database includes a large number of tools to help assess readiness and the resources and needs of your region. http://www.countyhealthrankings.org/resources?f[0]=field_global_action_steps%3A18389

- **Community Commons – Community Health Needs Assessment Toolkit**: This toolkit is a free web-based platform designed to help hospitals and organizations understand the needs and assets of their communities, and work together to make measurable improvement in population health. http://assessment.communitycommons.org/CHNA/

Element 2: Leadership across the region and within organizations

What it is.

Simply put, leadership is the ability to guide or influence people. It is particularly important when bringing individuals and organizations together to accomplish a common task. Leadership has been the subject of study for centuries; it was part of the teachings of Confucius and Aristotle, even Sun Tzu's *The Art of War.* While the exact definition is still studied and debated, there are certain clear leadership skills and abilities. These include cultivating a shared and inspiring vision, thinking strategically, applying individual and collective intelligence, managing relationships and roles, using effective social skills in different situations, and being resilient, adaptable and able to manage change over time.

Improving health in and across a population requires leaders in several types of organizations and individuals to work together. **At a minimum, this should include groups from public health, health care, and other key stakeholders**. The stakeholders most important to be involved initially and over time may vary, including representatives from Medicaid, citizens or consumer groups, tribes, employers, educators, transportation officials, housing advocates, community service providers, the military, corrections administrators, farmers, and the faith community.

In this type of work, leadership is more like putting together a complex puzzle, rather than directing the actions of others from the top of a pyramid.

Why it is important.

Leadership is needed to bring this variety of groups together. Whether it is a single leader or a small group of people who provide the vision and inspiration and effectively guide others to get involved, creating this kind of momentum does not happen without leaders at the helm. This requires skills in

managing relationships and roles, strategy, and knowing how to find the right people. The organizations at the table will likely have differences in perspectives, organizational culture and terminology (e.g., beware of using acronyms that other people don't understand), and why they want to improve overall health in the population. Leaders of such population health improvement initiatives must be able to build bridges across these groups to create shared values and goals, while tapping into the motivations of the different organizations and individuals. Such leadership is best done by a "trusted broker" who understands the importance of being an informed yet neutral convener.

Leadership is important at many levels. For example, each participating organization and individual shows leadership when they choose to come to the table to be a part of this work. In addition to the work "at the table" to build common ground among different groups, a critically important aspect of leadership takes place *inside* each organization involved. In other words, successful health improvement efforts involve people who are, in turn, able to lead inside their own organization to create an inspiring vision and understanding of the high priority of improving population health.

The success of an effort like this depends on the engagement, commitment and involvement of each organization. This requires internal leaders who can inspire the people they work with to do their part for one or more of the activities described in this Guide. This willingness to get involved in health improvement, and adapt as the work evolves, is important for activities that, for any given organization, may include: assessing health needs and identifying existing assets in the region (Element 4); engaging in specific health improvement activities that fit with their organization's focus and role (Element 5); supporting data collection, measurement (Element 6) and joint reporting on the progress being made (Element 8); and, helping to expand (Element 9) and support the work over time (Element 10).

How it can be done, with examples.

Listed below are examples of reports or initiatives that address this topic.

- **The YMCA's Pioneering Healthier Communities (PHC):** PHC teams take a "shared leadership" approach with community partners, which has led to the revision of YMCA directives and activities based on a broader view of health. One of the seven leading practices that has emerged from these relationships is the need to "adapt to emerging opportunities." http://www.ymca.net/healthier-communities

- **Healthy Memphis Common Table:** This collaborative of community partners leads multiple population health improvement projects and oversees 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 including Medicaid, 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, bringing seemingly disparate elements of the community together to take a comprehensive view of health. http://www.healthymemphis.org/af4q.php

- **National Association of Medicaid Directors:** This offers a starting point to build leadership connections with Medicaid in any state. Medicaid is the nation's health care safety net, jointly

financed by the states and the federal government. Each state administers Medicaid, within a federal framework, so there is great variation regarding who is covered, the services included, and how the services are provided and paid for. Medicaid's role can be broad and complex: across the US, Medicaid pays for more than 40 percent of all births, the majority of publicly financed long-term care, HIV/AIDS related treatments, mental health services, and others. http://medicaiddirectors.org

Links to Resources.

Listed below are links to more information, tools and other resources about this topic.

- **Pioneering Healthier Communities — Lessons and Leading Practices:** This document shares the seven "leading practices" learned through YMCA initiatives and explains how other organizations can implement these principles. http://www.ymca.net/sites/default/files/pdf/phc-lessons-leading-practices.pdf

- **Working Together, Moving Ahead: A Manual to Support Effective Community Health Coalitions**: This handbook is designed to support those who participate in coalitions, provide staff support to coalitions, provide funding or in-kind resources to coalitions, or require their grantees to organize and utilize coalitions in their work. It provides practical advice on common concerns and problems facing coalitions. The Manual aims to get people thinking about why they have chosen to use coalitions in their work, about their assumptions in building coalitions, and about the structures and processes they are using with coalitions. http://www.policyarchive.org/handle/10207/21720

- **Community How-To Guide on Coalition Building:** This guide from the National Highway Safety Transportation Administration provides guidance on bringing together a diverse group of people in pursuit of a common goal. The guide is part of a set to assist with underage drinking prevention efforts; however, the information is not topic-specific and can be applied to various population health improvement projects. http://www.nhtsa.gov/people/injury/alcohol/Community%20Guides%20HTML/Guides_index.html

Element 3: An Organizational Planning and Priority Setting Process

What it is.

An organizational planning and priority setting process is the clearly defined approach that will be taken to define the goals, objectives, and activities of the population health improvement initiative. This is not simply an acknowledgement that planning and priority setting will happen, but rather a deliberate step to define *how* the planning will be done and *how* priorities will be identified.

Several models are available to use when defining and communicating the process that will be used for planning and setting priorities. Most models are cyclical, recognizing that planning and setting priorities is not a one-time activity but an ongoing process that should be designed to learn from what has already

occurred then adapt to improve the likelihood of success. Feedback loops are also a key feature, deliberately seeking out information or input, then using it to learn from experience and improve. One commonly used model is the "Plan-Do-Study-Act" process, illustrated below.

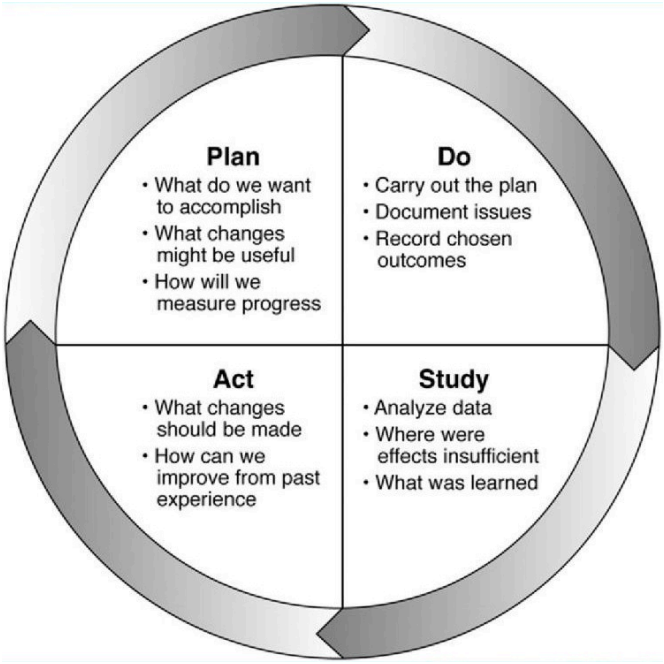

Figure 3 Plan-Do-Study-Act Cycle. Source: Medscape / AGA 2012

In each of the segments in the Plan-Do-Study-Act model shown above, there are steps that require more detailed thinking. For example, under the Plan step, when determining goals and changes that might be useful to improve health in your region, there are a number of ways to think about what actually impacts or drives health.

Any region – whether a neighborhood, county, state, or other geopolitical area involving multiple organizations or systems that affect the determinants of health – is naturally complex. This complexity will influence the planning and related evaluation of efforts to improve population health. Considering models, whether those above or others listed below, can help clarify the process or approach that will be used, and can reveal ideas for specific focus areas important for a given population.

An important part of the planning process is deciding the pathway forward, which is not easy. Unfortunately, most efforts to improve population health neglect to include evaluation from the outset. Determining – up front – how you will assess, measure and learn from the progress of the work over time will help define the pathway forward, and then guide decision-making and refinements along the way.

Using clear approaches or models can inform how the evaluation is designed and implemented. Such models are helpful to highlight aspects of the work that will be useful to assess as part of the evaluation. This can include evaluating the program overall, measuring the success of key processes, assessing the impact of the work, and changes in health outcomes over time. These issues are discussed further under Element 6.

Why it is important.

Given the need to build and maintain trust with participating organizations, being transparent about *how* decisions are made is a necessary backbone of the work. Achieving results is what motivates people – that is, healthier individuals and populations, along with the related benefits of better health such as lower health care costs, less absenteeism, better workplace productivity, and reduced financial impact affecting schools, community services, jails and so on. However, the intended results will not be achieved if the participants are not clear about how the overall group expects to get there, or if the decision-making process is perceived as being unfair.

Some may want to jump into getting the work done to achieve better outcomes, rather than spending time up front defining the process. However, defining the way in which the groups at the table will make plans and set priorities, then deliberately communicating how that process is being followed, is a core element of success. Over time, modifications to the process being used are likely to be needed as the initiative matures and adapts to changing circumstances.

In addition, too often evaluation is treated as an afterthought; this increases the likelihood of losing important information because it is not being captured while it is happening (or soon afterward). Incorporating evaluation into the process from the beginning also creates the opportunity to gather important information that will be useful for learning in real time to adapt and improve, and for making a compelling case to current and potential partners and funders.

How it can be done, with examples.

Listed below are examples of reports or initiatives that address this topic.

- **The National Service Frameworks:** This set of frameworks for improving care in various high-priority fields was developed by advisory groups from diverse fields, such as patient groups and non-profit organizations. The frameworks determine research-based strategies and interventions, along with detailed processes for measurement and specific, timed targets. Each one is intended for use by all facets of the National Health Service (NHS) public health system, and as a resource for collaborative organizations spanning social services, community institutions and more.
  http://www.nhs.uk/nhsengland/NSF/pages/Nationalserviceframeworks.aspx

- **The Family Wellness Warriors Initiative:** This organization works one-on-one with Alaska-native communities to plan for, implement and assess a three-year-model aimed at reducing domestic violence, abuse and neglect. The three-year model and curriculum was developed by a steering committee of Alaska-native people and mental health professionals, who worked on adaptation and development for two years by analyzing research-based evidence and projects from around the world.
  http://www.fwwi.org/index.cfm

Links to Resources.

Listed below are links to more information, tools and other resources about this topic.

- **Guide to Measuring the Triple Aim**: Population Health, Experience of Care, and Per Capita Cost: This 2013 white paper from the Institute for Healthcare Improvement offers a useful logic model

for considering drivers of health, with related examples for measuring population health. http://www.ihi.org/resources/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx

- **Practical Playbook:** The "Stages of Integration" framework encourages organizational planning and offers guidance on the process. http://playbook.smashingboxes.info/

- **County Health Rankings and Roadmaps:** The "Roadmaps" framework provides guidance on the organizational planning process and how to determine priorities. http://www.countyhealthrankings.org/roadmaps

- **First Things First: Prioritizing Health Problems:** This tool from the National Association of County and City Health Officials (NACCHO) describes five prioritization methods for identifying health issues in population health improvement projects and initiatives. http://www.naccho.org/topics/infrastructure/accreditation/upload/Prioritization-Summaries-and-Examples.pdf

- **Plan, Do, Study, Act (PDSA):** The PDSA model is utilized by the National Health Service in the United Kingdom to encourage trials of new policies before implementation. The model consists of four recommended steps to test an idea and assess its impact: planning the change to be tested or implemented (Plan); carrying out the test or change (Do); Studying data from before and after the change and reflecting on what was learned (Study); and, finally, planning the next change cycle or full implementation (Act). http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html

- **ReThink Health**. This suite of interactive tools opens up new ways of looking at population health improvement. The intention is to guide leaders in considering the impacts of different policies and interventions and make better and more creative decisions about redesign. http://rippelfoundation.org/rethink-health/dynamics/

Element 4: A Community Health Needs Assessment and Asset Mapping Process

What it is.

A community health needs assessment and asset mapping process is a way to look at the current environment or situation to identify any health-related gaps or needs and potentially helpful resources or strengths. Needs assessments typically involve defining the geographic focus or the region of interest (e.g., zip code, county, state, service area), collecting and interpreting data (e.g., population characteristics or demographics, health status), and identifying and prioritizing the health needs in that region. Similarly, asset mapping is a deliberate review of a given region, yet focused on the strengths or positive attributes rather than deficiencies or needs. Assets can be tangible – such as financial strength, physical structures, businesses or other organizations, natural resources – or intangible, such as

individual or organizational skills or capabilities, regional heritage, readiness for change that can lead to improvement, resiliency and adaptability, or other special community characteristics or attributes.

While asset mapping and health needs assessments might be characterized as being separate and potentially at odds, the processes are complimentary and both need to be done. Moreover, to effectively approach population health improvement, health needs assessments and asset mapping processes that may have historically been done by several different organizations should be combined to create a shared understanding based on a more comprehensive view of the region. Both are important ways to listen and learn about what is already in place and what is needed.

Why it is important.

Conducting a community health needs assessment and asset mapping will ensure that the selected priority areas for the population health improvement will align with actual needs and make best use of resources in the region. Doing this work as a larger collaborative of organizations, rather than developing competing reports, will eliminate duplication of effort, reduce expenditures, and increase effectiveness by creating a shared understanding among all of the groups involved in the initiative.

The use of community health needs assessments is growing quickly and presents one of the most fertile opportunities for coordinated population health improvement efforts. This is largely due to changes in federal law that governs non-profit hospitals registered with the IRS as a 501(C)(3) organizations. There are nearly 3,000 non-profit hospitals in the US, according to the American Hospital Association. The new IRS requirement affecting these hospitals passed into law in 2010 as part of the Affordable Care Act. It directs non-profit hospitals to conduct a community health needs assessment once every three years –in collaboration with public health entities and others – and to develop and annually update a related "implementation strategy" which is an improvement plan with measurable goals and objectives. Starting in 2012, hospitals must conduct such assessments or pay a sizeable fine. The IRS regulations, which are soon to be finalized, requires a non-profit hospital to consult with public health organizations and encourages collaboration with others in the community served by the hospital.

In addition, the IRS has adopted a standardized nationwide reporting system (Schedule H filed with non-profit hospitals' annual Form 990) that captures more complete information about the community benefit activities of each hospital, and includes a standard definition of "community benefit." Based on the IRS definition, non-profit hospitals must engage in activities that include "community health improvement" work, done by the hospital or by providing support to community-based organizations, in addition to "community building" work. Community building efforts must have a direct connection to promoting the health of the population served by the hospital. Examples might include: physical improvements and housing; economic development; environmental investments; leadership development and training for community members; coalition building; community health improvement advocacy; and, workforce development.[19]

The annual value of the non-profit tax exemption for non-profit hospitals exceeded $12.6 billion in 2002. With the new IRS requirement that non-profit hospitals must engage in community health needs

[19] "Encouraging Nonprofit Hospitals to Invest in Community Building: the Role of IRS 'Safe Harbors'" S. Rosenbaum, A. Rieke, M. Byrnes. Health Affairs Blog, February 11, 2014. http://healthaffairs.org/blog/2014/02/11/encouraging-nonprofit-hospitals-to-invest-in-community-building-the-role-of-irs-safe-harbors/

assessments and annual improvement plans, and report their population health improvement or community building activities, there is the potential for greater coordination of – and investment in – population health improvement aimed at meeting the specific needs in the region. If non-profit hospitals were to shift 20 percent of their community benefit expenditures to population health improvement efforts, this would infuse $2.2 billion in additional funds for prevention.[20]

How it can be done, with examples.

Listed below are examples of reports or initiatives that address this topic.

- **Vermont Blueprint for Health:** As part of the implementation of the Blueprint, various workgroups and teams are created, including a Community Health Team and an Integrated Health Services workgroup, to assess specific needs and coordinate efforts within the community and in the clinical care field. http://hcr.vermont.gov/blueprint

- **DC Health Matters:** This community-driven, interactive web portal provides local health data, resources, best practices and information about local events to help community organizations and researchers understand and act upon health issues affecting D.C. communities. The database is a collaborative effort and a "living" project that continues to evolve as users contribute and share the information, which can be used to assess population health needs and assets. The website provides demographic, economic and health data for the communities of the D.C. area and includes report-creation tools. www.dchealthmatters.org

Links to Resources.

Listed below are links to more information, tools and other resources about this topic.

- **ACHI Community Health Assessment Toolkit:** The toolkit provides detailed guidance on six core steps of a suggested assessment framework, including, but not limited to, data collection. http://www.assesstoolkit.org/

- **Asset Mapping from the Southern Rural Development Center:** This article explains a process for mapping the assets of a community and provides guidance on collaborating with various organizations and individuals with the goal of community development and enhancement. The article offers an overview of the needs assessment process and then a step-by-step work plan for each element of the model. http://www.nebhands.nebraska.edu/files/227_asset_mapping.pdf

- **Practical Playbook:** The "Stages of Integration" framework encourages public health entities to analyze the most recent community health needs assessment to identify population health

[20] "Encouraging Nonprofit Hospitals to Invest in Community Building: the Role of IRS 'Safe Harbors'" S. Rosenbaum, A. Rieke, M. Byrnes. Health Affairs Blog, February 11, 2014. http://healthaffairs.org/blog/2014/02/11/encouraging-nonprofit-hospitals-to-invest-in-community-building-the-role-of-irs-safe-harbors/

projects. The framework also offers guidance on the prioritization process and how various entities can work together to identify needs in the community.
http://playbook.smashingboxes.info/integration/organize-prepare

- **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. As a resource, the Regional Equity Atlas has been used by various AF4Q projects to identify target areas for health improvement in specific geographic areas.
http://clfuture.org/equity-atlas

- **Community Commons – Community Health Needs Assessment Toolkit**: This toolkit is a free web-based platform designed to assist hospitals and organizations understand the needs and assets of their communities, and work together to make measurable improvement in health in the community.
http://assessment.communitycommons.org/CHNA/

- **Resources for Implementing the Community Health Needs Assessment Process:** This set of resources from the CDC helps to translate the requirements of the Affordable Care Act, with the intent to encourage active engagement between hospitals and public health.
http://www.cdc.gov/policy/chna/

Element 5: An Agreed-Upon, Prioritized Subset of Health Improvement Activities

What it is.

An agreed-upon, prioritized subset of health improvement activities is a list of strategies and actions that will be taken by organizations or individuals involved in population health improvement initiatives. Together, the organizations identify one or a few high priority topics for which they will lead health improvement activities in the region. This topic or topics are identified as a result of the group's planning, assessment and decision-making. These priority topic(s) will drive the individual activities that each organization commits to doing with the people in the population or subpopulation(s) with whom they interact.

Why it is important.

With so many factors that can influence health, even the best efforts of a solo project or program are at risk of having little impact. Population health is complex, involving a number of different drivers and determinants, making it difficult for any one organization alone to make a measureable difference. This can lead to a sense that the problem is too big to solve and that improving individual health and the health of the population overall is beyond the control of any single organization or type of group.

Together, organizations can accomplish far more than any one could ever do alone. By collectively identifying one or a few top priority focus areas, and individually committing to engaging in specific

activities that promote improved health related to the focus, the collective initiative is much more likely to make an impact and see measureable improvement. This alignment also helps to create a shared awareness about the importance of the particular priority issue – whether that be reducing domestic violence or child abuse (or the incidence of any adverse childhood event), addressing depression and other mental health needs, reducing obesity, or promoting stronger social and family connections that are important to overall wellbeing.

How it can be done, with examples.

After drawing from insights from the community health needs assessment and asset mapping process described under Element 4 above, high priority topics or needs could then be considered in more detail. Identifying contributing factors and likely causes for a given need or problem can reveal potential solutions. One approach might be to use a simple "root cause map" like the one shown below.[21]

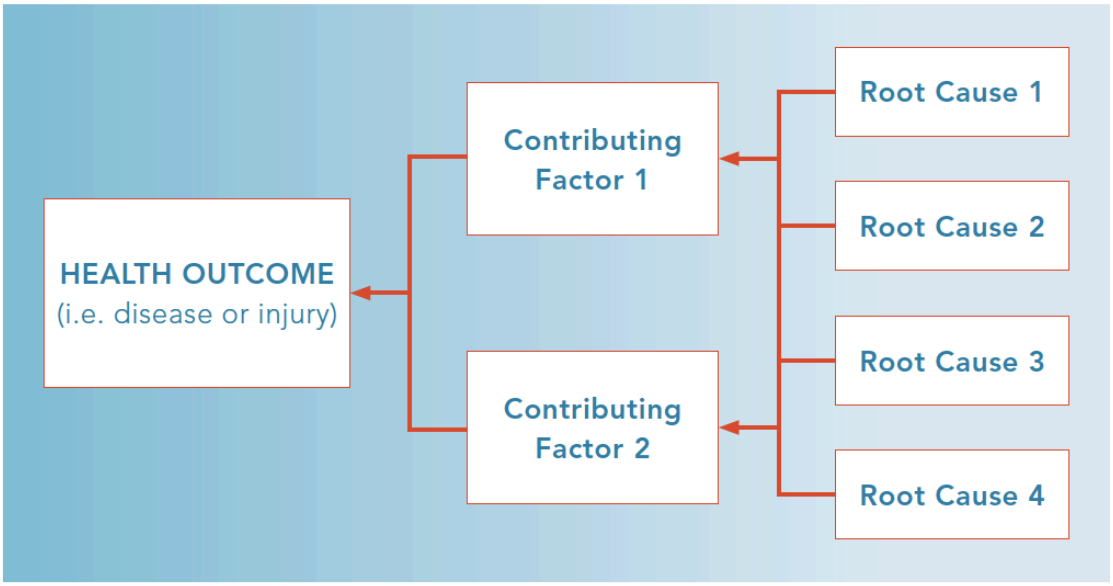

Figure 4 A Simple Root Cause Map

As indicated by the map above, each need stems from contributing factors, which can be traced to basic or root causes. Certain causes – stemming from genetics or biology, for example – may be difficult to address. On the other hand, root causes such as unsafe neighborhoods, poor access to affordable and healthy food options, a community ethic that tolerates unhealthy behavior, and so on, might illuminate possible actions or changes that can disrupt or eliminate the root cause of the poor health outcome.

As an example, if everyone agrees on a priority focus to reduce obesity in the region, a variety of activities could be identified for different organizations to commit to doing. The actions might include:

[21] Rudolph, L., Caplan, J., Ben-Moshe, K., & Dillon, L. (2013). *Health in All Policies: A Guide for State and Local Governments*. Washington, DC and Oakland, CA: American Public Health Association and Public Health Institute.

- *Employers – including public, private and the military* – ensuring that salads and other nutritious foods are offered in the cafeteria and are noticeably more affordable than unhealthy options;

- *City planners and schools* working together to make neighborhoods around schools safer for biking and walking;

- *Hospitals, doctors and nurses* measuring the body mass index of every patient and, where needed, discussing ideas for better nutrition and adding physical activity;

- *Grocery stores* highlighting healthy food options in each aisle and offering cooking demonstrations of healthy recipes;

- *Community groups* starting a Saturday market where local farmers can sell fresh fruits and vegetables in underserved areas;

- *Churches and others in the faith community* organizing weight loss support groups and including being at a healthy weight as one of the spiritual topics;

- And so on…

Listed below are examples of reports or initiatives that address this topic.

- **Healthy Base Initiative:** The aim is to assess best practices and lessons learned at 14 military bases selected by the DOD, to promote healthier and more resilient service members, families, retirees, and civilian employees.
  http://www.militaryonesource.mil/hbi

- **The Blue Zones Project:** Through international research, the Blue Zones Project has identified nine healthy living principles and provides guidance on health improvement activities within these nine principles. The project uses social media and an online forum to communicate these ideals and foster connection around healthy living information and tips. This includes a "daily challenge" sent out to participants via email, with a corresponding forum for participants to share successes and advice. The website also provides guidance for individuals and organizations, such as schools, on implementing these principles.
  http://www.bluezones.com/

- **The National Prevention Strategy:** This strategy was developed by a council comprising 17 heads of departments, agencies and offices in the federal government and includes a set of directives designed for broad implementation based on promoting wellness and prevention. The plan lists strategic directions and priorities along with related actions and guidance on measuring progress. Priorities span clinical care fields and community environments to individual behaviors, and include: Tobacco Free Living, Preventing Drug Abuse and Excessive Alcohol Use, Healthy Eating, Active Living, Injury and Violence Free Living, Reproductive and Sexual Health and Mental and Emotional Well-being.
  http://www.surgeongeneral.gov/initiatives/prevention/strategy/

- **Let's Move:** Let's Move! is an executive initiative dedicated to solving the problem of childhood obesity. The program emphasizes that everyone has a role to play in reducing childhood obesity

and 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.
http://www.letsmove.gov/

Links to Resources.

Listed below are links to more information, tools and other resources about this topic.

- **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 determine which interventions work for improving population health in various settings. 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 program and policy interventions, effective interventions for specific communities, and the cost and potential return on investment of interventions.
http://www.thecommunityguide.org/index.html

- **A Compendium of Proven Community Based Prevention Programs**: This report from The Trust for America's Health and the New York Academy of Medicine highlights nearly 80 evidence-based prevention programs that have been proven to improve health and save lives. Topics addressed include tobacco use reduction, asthma, injuries, sexually transmitted infections, alcohol abuse, physical activity and eating habits.
http://healthyamericans.org/assets/files/Compendium_Report_1016_1131.pdf

Element 6: Selection and Use of Measures and Performance Targets

What it is.

Selecting and using measures and performance targets starts with the process of identifying goals and measurable objectives that are relevant to the priority topics and associated health improvement activities. Available data sources must be identified for each of the measures so that they can be used to periodically assess the progress toward improving health and meeting the performance targets. Some regions may choose a set rate of improvement as a reasonable performance target, or a specific level of performance such as "everyone should achieve a score of at least 90%." Others seek to exceed national or statewide benchmarks, such as the statewide average rate or the national top ten percent. As with measures, performance targets are only possible to assess if the data are available.

Why it is important.

The purpose of this work is to *improve* health across a population. Measuring progress, ideally against performance targets, is the only way to know whether the initiative is on track. Measurement against performance targets can also reveal when it's time to modify the approach in order to achieve better results. Measurement is one important part of evaluation, as described under Element 3.

Public and private sector leaders are increasingly holding certain types of organizations accountable for improving health outcomes, including public health agencies, health care organizations and health plans. The accountability is also expanding into other sectors: consider "health in all policies" approaches that recognize the national imperative to improve health, understanding that health outcomes are affected by decisions and actions of a wide range of organizations and individuals. To meet accountability expectations, measurement is needed to show that health outcomes are improving.

The state of available measures and data sources is an interesting mix of abundance, with literally hundreds of metrics and a vast array of data from many sources. Many organizations are 'drowning in raw data' yet most decisions are being made without the use of any data or measurement of results. The process of using many of the currently available data sources requires specialized skill and sufficient time to address problems such as: finding the relevant data source; unlocking data that is available only in a "raw" format; and, creating meaning from that data through analysis and visual presentation of the results in engaging, useful ways. What is needed is better access to available data that is translated into 'actionable' information that can be used by leaders in public health, health care and other sectors to assess and improve population health.[22]

NQF has endorsed 64 of measures of health and well-being (i.e., population health) measures, across all levels of analysis, including healthcare providers and communities. The measures address population health in the following topic areas:

- Measures that assess health-related behaviors (e.g. smoking, diet) and practices that promote healthy living
- Community-level indicators of health and disease (e.g. 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 such as measures that focus on built environments

Even with these available sources, there are also significant gaps in the measures available for population health improvement. Work is being done on a number of fronts to fill those gaps. NQF, for example, is engaged in a range of projects intended to help address the gaps in essential measures for population health improvement.

NQF is working on identifying and endorsing measures that focus on healthy lifestyle behaviors, and community interventions that improve health and well-being in addition to social and economic conditions. There is a strong interest in community- and population-level measures that are appropriate for government, community, health care system, and shared accountability among a variety of sectors and organizations. Examples of measure topics that NQF is seeking for consideration for endorsement include:

- Health outcomes of individuals, including health/functional status, life expectancy, mortality, and quality of life

[22] "Local Health Data: From Buried Treasure to Everyday Commodity" A. Krackov, Health Affairs blog, September 9, 2013. http://healthaffairs.org/blog/2013/09/05/local-health-data-from-buried-treasure-to-everyday-commodity/

- Measures that assess the health of a total population or a subset of a population (subpopulation), including disparities across the population
- Measures that cover the lifespan, including those that focus on children, adolescents, and the elderly
- Adoption of healthy lifestyle behaviors
- Population-level measures in priority areas (e.g., obesity, physical activity, tobacco use, nutrition and diet)
- Receipt of health promotion and education services;
- Social, economic, and environmental determinants of health with a clear connection to population health outcomes

NQF is providing guidance for measure developers to ensure a shared understanding of population health improvement and the related needs for new or modified measures. Such guidance recognizes that population health measures can reflect any point along the following continuum:

- Upstream factors that determine health, including socioeconomic, social norms, physical environment factors and preventive health services
- Individual factors (i.e., behavior and genetics)
- Intermediate health outcomes (e.g., rates of disease and injury)
- Various states of health, including functional status and death
- Quality of life

Several types of measure gaps were identified in NQF's projects, including the need for more outcome measures; population-level blood pressure screening measures for the Million Hearts Campaign; and comprehensive measures, like composites that take into account process, outcome, access, structure, population experience, population management, population costs, and population services. Other recommendations include measures with a focus on built environments, especially those that assess children's health within schools; measures that assess patient and population health outcomes that can be linked to public health activities like improvements in functional status; assessments of community interventions to prevent elderly falls; and measures that focus on counseling for physical activity and nutrition in younger and middle-aged adults (18-65 years).

How it can be done, with examples.

There is no universally recommended, practical set of population health measures for which there are widely available data sources. Fortunately, in June 2014, the Institute of Medicine is expected to release a report with a core set of high level measures for population health improvement.

Given the dependence on available data, which can differ by region, the best approach is to choose an ideal menu of measures, then use what is possible now and expand over time. In other words, take a phased approach to measuring performance based on available data.

Among measures to consider using include disparities-sensitive measures to assess differences in health status or outcomes for ethnic or racial groups, and other vulnerable populations such as people with disabilities or the lesbian / gay / bisexual / transgender community. Available data sources continue to expand as well, in part due to increased reporting requirements and support for transparency in public and private activities. Advances in technology have enabled collection and sharing of de-identified

health care data. In addition, new data sources are appearing such as consumer-generated data drawn from discussions on social media.

Taking a practical approach is necessary. Identify the basic data available for the region, and use the sources that are relevant, understandable, and timely if possible. Over time, what may start as a short list of population health measures will undoubtedly become more robust as the field of useable measures evolves.

Listed below are examples of reports or initiatives that address this topic.

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

- **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. Measures described in the report are based on: the centrality of primary care; a distinction between clinics or clinicians and community-based resources; 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/

- **Correctional Health Outcomes and Resource Data Set:** This project focuses on care within correctional facilities and aligning measures with those used in “mainstream” care. 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.
  http://www.ncchc.org/chords

- **Health in All Policies: A Guide for State and Local Governments:** This 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**.** Using the Healthy Community Framework, this identifies 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.
  http://www.phi.org/resources/?resource=hiapguide

- **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. Four key 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.
  http://www.healthypeople.gov/2020/default.aspx

- **ESRI Health Information Maps:** Using weekly data updates from the CDC, this interactive map uses social media posts from Twitter to indicate flu outbreaks.
  http://www.esri.com/news/maps/2013-flu-outbreak/information-map.html

Links to Resources.

Listed below are links to more information, tools and other resources about this topic.

- **Population Based Measures Endorsed by NQF:** This list or portfolio of measures are those which have been identified by the National Quality Forum as being most appropriate for measuring health improvement at different population levels such as county, state and national. [Link to QPS portfolio will be added]

- **Disparities-Sensitive Measures Endorsed by NQF:** This list or portfolio of measures are those which have been identified by the National Quality Forum as being most appropriate for assessing disparities, with particular focus on health improvement. [Link to QPS portfolio will be added]

- **Health Indicator Warehouse:** This online library provides access to national, state and community health indicators, linked with evidence-based interventions. It serves as the data hub for the HHS Community Health Data Initiative and is a collaboration of various agencies within the department. The Health Indicator Warehouse is referenced by the County Health Rankings and Roadmaps to Health as a resource for those working on population health projects.
  http://healthindicators.gov/

Element 7: Audience-specific Strategic Communication

What it is.

Audience-specific strategic communication is the ability to customize messages and approaches in ways that effectively connect with the target individuals or organizations. While the vision and goals of the initiative should stay consistent, the content, style and even the method of communication may need to be adapted to speak to the values, priorities and cultural filter of the intended audience. This requires cultural humility on the part of the communicator, understanding that what is intended may not always be what is heard. The goal of audience-specific strategic communication is to deliberately understand the perspective of others, then communicate in ways that reflect that understanding.

Why it is important.

Effective communication can make or break this work. As described in Element 2, the wide range of organizations and individuals who have role in improving health means that communication must take place in ways that span different cultures, terminology, goals and values. Addressing differences across audiences in addition to effectively reducing disparities, which requires culturally sensitive interaction, is at the heart of strategic communication.

How it can be done, with examples.

Many sectors use unique terminology that can be confusing to others, and this is especially true in health care and public health. Using words that are easy for everyone to understand, explaining commonly misunderstood terms, and avoiding acronyms are a few basic principles to follow.

Communication that works for one group will not work for everyone. For example, some individuals and organizations are driven by business principles and will look for the value-proposition and evidence of likely return-on-investment in any initiative. Understanding that time and financial resources are limited, and cost reduction is imperative, these groups will respond to discussions about improving health at the population level if there is a compelling business case. At the same time, some individuals and organizations engage in population health improvement because it reflects social values such as equity and fairness, dignity and opportunity. In this case, discussing population health improvement using business-oriented perspectives and terminology may not be as effective.

Listed below are examples of reports or initiatives that address this topic.

- **Health in All Policies**: Exploring a collaborative approach to improving population health, "Health in All Policies" offers guidance for state and local governments on incorporating health considerations into diverse sectors of public policy. The glossary includes a comprehensive and generally applicable list of terms that spans health, business strategy, environmental planning, sociology and policy.
  http://www.phi.org/resources/?resource=hiapguide

- **HHS Action Plan to Reduce Racial and Ethnic Disparities:** This 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, including making a strong case for providing

culturally sensitive communication and care.
http://www.minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=285

- **White Earth Nation Tobacco Coalition:** This action plan to reduce commercial tobacco use in the tribal community of White Earth in Minnesota focuses on culturally relevant outreach materials and policy guides to provide information about the effects of smoking and its cultural impact on the tribe. Materials are aimed at individuals, health care providers and community institutions, and include the use of language specific to the tribal community, such as use and explanation of the word "Asayma" to mean "sacred tobacco."
http://www.whiteearth.com/programs/?page_id=405&program_id=4#Tobacco

- **Family Wellness Warriors Initiative (FWWI):** This initiative involves working with communities to implement a three-year model designed for Alaska-Native areas. The model was developed by a group of 30 stakeholders, including Alaska-Native people and mental health professionals, who researched internationally for programs pertaining to domestic violence and abuse. The model is designed for scalability within Alaska-Native areas, since it is designed specifically to be culturally relevant to these communities.
http://www.fwwi.org/index.cfm

- **Primary Care and Public Health: Exploring Integration**: This report 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.
http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx

Links to Resources.

Listed below are links to more information, tools and other resources about this topic.

- **Simply Put: A Guide for Creating Easy-to-Understand Materials:** This resource from the Centers for Disease Control and Prevention (CDC) offers insight on how to use plain language, visuals, clear formatting and cultural sensitivity to communicate effectively with health-related materials.
http://www.cdc.gov/healthliteracy/pdf/simply_put.pdf

- **YMCA Pioneering Healthy Communities:** This is a practical toolkit that includes a useful framework for considering how to communicate effectively, using culturally respectful plain language.
http://www.ymca.net/healthier-communities

- **Disseminating Relevant Health Information to Underserved Audiences: Implications of the Digital Divide Pilot Projects:** This paper examines the digital divide and its impact on health literary and communication. The digital divide can be a significant impediment in health literacy and information dissemination.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1255755/

Element 8: Joint Reporting on Progress Toward Achieving Intended Results

What it is.

Joint reporting on progress toward achieving the intended results is a way for the participating groups and organizations to share insights from the needs assessment and asset mapping (Element 4), the evaluation activities (Element 3), and the use of measures and performance targets (Element 6).

Why it is important.

Joint reporting establishes the accountability of each organization to the others in the initiative. In addition, pulling together the results for actions across the initiative (described in Element 5) and sharing that information with all participants keeps everyone informed about the progress of the work. It also helps to identify where changes might be needed to improve results. This reporting should align with the areas of evaluation that are part of the planning and priority setting process (Element 3), to reinforce the shared commitment to achieving the intended results at a variety of levels.

How it can be done, with examples.

In addition to health outcomes, the content of such reports might address impact on social values or perceptions about health, return on investment, and elements that indicate the progress of the overall initiative. Such reporting might typically begin as private sharing of results among the collection of participating organizations, either reported individually or developed as a single report about the collaborative and individual efforts. Given the importance of transparency and accountability, ultimately the goal is to share the progress reports with the general public.

Listed below are examples of reports or initiatives that address this topic.

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

- **Hennepin Health:** This pilot 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. http://www.hennepin.us/healthcare

- **National Health Service Care Data:** While the National Health Service (NHS) in the United Kingdom has collected and used hospital data for the last few decades as part of its national

database, a new initiative is expanding the reach of the NHS Information Centre to include patient information from General Practitioner (GP) doctor surgeries across the U.K. The NHS claims that "better information means better care" and will ensure consistency in quality and safety and highlight areas where more investment is needed.
http://www.england.nhs.uk/ourwork/tsd/care-data/

Links to Resources.

Listed below are links to more information, tools and other resources about this topic.

- **Community Health Ranking and Roadmaps – Tools and Resources:** This resource shows results for a number of measures and indicators by county across the United States, and clearly describes their methods for developing the rankings that are reported.
http://www.countyhealthrankings.org/Our-Approach

- **Data.gov:** The U.S. government's data portal provides access to more than 1100 federal, state and local data sources, as well as tools and research resources. The "Health" section includes data sets, tools and applications related to health and health care and can be used as a resource for groups or individuals looking for examples of data or actual data sets for reporting purposes.
https://www.data.gov/health/

- **The Network for Public Health Law: Checklist of Information Needed to Address Proposed Data Collection, Access and Sharing:** This tool provides a checklist to assist public health practitioners in providing relevant factual information to address issues of legality, privacy and ethics.
https://www.networkforphl.org/resources_collection/2014/01/07/400/tool_checklist_of_information_needed_to_address_proposed_data_collection_access_and_sharing

Element 9: Indications of Scalability

What it is.

Scalability is the ability for an initiative to expand, either by becoming more deeply involved in the region – for example, increasing the number of participating organizations or taking on new priority topics and related health improvement activities – or by spreading to additional regions. The latter can happen either as the initiative grows geographically or when a new group learns from the work and decides to take a similar approach within their own region.

Why it is important.

Poor health is a problem everywhere in the US. To the degree that existing health improvement efforts are refined and new successful initiatives started, from which others can learn then adopt in their own region, this expands the possibility for achieving better health for more people. That being said, achieving traction in other regions may not always be possible, especially if the population health improvement work relies on assets or characteristics that are unique to a region.

How it can be done, with examples.

During the planning process (Element 3), consider and emphasize activities that can be easily expanded or adopted by others. At the same time, during the asset mapping process (Element 4) consider which assets might be unique to either one sub-population or to a smaller geographic part of the whole geopolitical area. These unique assets may limit the ability to spread the initiative across the entire population and/or geopolitical region.

Listed below are examples of reports or initiatives that address this topic.

- **State Innovation Models Initiative:** This initiative led by the Centers for Medicare & Medicaid Services (CMS) is intended to foster the testing and development of state-based models for improving health system performance through multi-payer payment reform and other system changes. The projects are broad-based and focused on enrollees of Medicare, Medicaid and the Children's Health Insurance Program (CHIP). The initiative is exploring models that could form a foundation for expansion into larger health system transformation.
  http://innovation.cms.gov/initiatives/state-innovations/

- **Beacon Communities Initiative:** This program is currently operating in 17 communities across the U.S. and focuses on exploring how health IT investments and Meaningful Use of electronic health records (EHR) can advance a goal of patient-centered care, improve health and lower cost. The communities are making inroads in the development of secure, private and accurate systems of EHR adoption and health information exchange, with the goal of helping the nation transition to EHR, while creating a collaborative community that can share lessons and leading practices.
  http://www.healthit.gov/policy-researchers-implementers/beacon-community-program

Links to Resources.

Listed below are links to more information, tools and other resources about this topic.

- **Let's Move Initiative:** This national initiative focused on reducing childhood obesity uses its website as a tool for sharing best practices and promotional material that can be used by different sectors of the community. The initiative has encouraged "Let's Move Meetup" programs in more than 400 cities nationwide, where community members get together to share success stories and discuss ways to tackle childhood obesity. Let's Move also uses its Facebook page as a connector for communities to share tips and news from across the country.
  http://www.letsmove.gov/

- **Practical Playbook:** This resource for public health and primary care groups features an interactive tool that guides users through the stages of integration for population health improvement projects. Information on how to scale up efforts is included. Note: The Practical Playbook website, including the interactive tool, is currently under construction and is set to re-launch "in early 2014."
  http://www.practicalplaybook.org/

Element 10: A Plan for Sustainability

What it is.

Sustainability is essentially the ability to continue operating and remain productive over time. In addition to developing a sustainable business model, adaptability and resilience are key characteristics of sustainable initiatives.

Why it is important.

In the current policy environment, health improvement has gained new relevance: poor health outcomes are widely understood as a major problem, coupled with unsustainable health care costs. Population health improvement is a complex field, and although public health agencies and others have been working to improve population health for years, the only way to achieve a positive impact is through multifaceted, sustainable approaches that address health improvement in activities across all of the determinants of health over the long term.

How it can be done, with examples.

Developing a sustainability plan or a business plan based on a sustainable model is the most effective approach. Knowing what approaches are sustainable is not an easy task. For example, receiving a multiyear grant or being funded through a government project are likely no substitute for a solid sustainability plan, as even multiyear grants and government programs eventually come to an end.

Opportunities exist given the rapidly changing health policy environment. When engaging in population health improvement, where there is the ability to motivate changes that are structural, this can increase the likelihood that the change will be sustained. Examples include new or revised commitments (e.g., public or private policy or contract provisions that incentivize better health or incorporate health in all policies), new patterns of care and coordination among different organizations, and linking medical and public health information systems. Examples of new policy opportunities 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 (see Element 4), and Public Health Accreditation.

While activities that encourage changes in public or private policy sometimes involve political advocacy, this is not always the case. An example of a private sector policy change is to support employers in encouraging employees to use preventive services and smoking cessation services to realize the full value of this health coverage. Employers could also begin assessing and reporting (Element 8) the degree to which their employee population is using such benefits.

Listed below are examples of reports or initiatives that have successfully addressed this topic.

- **Health in All Policies:** The Health in All Policies guide for state and local governments defines sustainability as “the need of society to create and maintain conditions so that humans can fulfill social, economic, and other requirements of the present without compromising the ability of future generations to meet their own needs.” The document focuses on environmental sustainability as an essential part of ensuring the longevity of health improvement plans, with

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

- **A Healthier America 2013: Strategies to Move from Sick Care to Health Care in Four Years:** This guide for improving the nation's health system includes a focus on various strategies and priorities for achieving sustainability, in addition to recommendations for governmental funding shifts. Suggested policies include ensuring sufficient and stable funding for public health departments, with recommendations to explore new funding models based on supporting basic capabilities.
http://healthyamericans.org/report/104/

- **Correctional Health Outcomes and Resource Dataset (CHORDS):** CHORDS is a quality improvement initiative that provides a national performance measurement and data sharing system within the correctional health care field. The project focuses on the importance of benchmarking to enhance the quality and effectiveness of care across the correctional health care system.
http://www.ncchc.org/chords

- **Moving Healthy:** The U.S. Department of Transportation Federal Highway Administration (FHWA) has set out policy guidelines to ensure the integration of health-related considerations in the planning and execution of its programs. The FHWA claims that health is implicit in transportation, and the agency has a responsibility to ensure the promotion of positive health outcomes and the mitigation of negative health outcomes through the programs and resources it provides, such as safe and accessible facilities for biking and walking.
https://www.fhwa.dot.gov/planning/health_in_transportation/resources/moving_healthy.cfm

- **National Prevention Strategy:** This national initiative aims to create healthy and safe communities, expand clinical and community-based preventive services, empower people to make healthier choices and eliminate disparities through four strategic directions and seven targeted priorities. The Strategy uses Healthy People 2020 as a foundation, and provides recommendations based on the latest scientific research, with emphasis on the economic benefits of preventing disease. The overarching goal of achieving a prevention-oriented society where all sectors work together to improve health for all Americans.
http://www.surgeongeneral.gov/initiatives/prevention/strategy/

- **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 determine which interventions work for improving population health in various settings. 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 program and policy interventions, effective interventions for specific communities, and the cost and potential return on investment of interventions.
http://www.thecommunityguide.org/index.html

Links to Resources.

Listed below are links to more information, tools and other resources about this topic.

- **Healthier Worksite Initiative**: This resource from the CDC addresses workforce health promotion and offers information, resources, and step-by-step toolkits to help worksite health promotion planners in the public and private sectors improve the health of employees. http://www.cdc.gov/nccdphp/dnpao/hwi/

- **A Sustainability Planning Guide for Health Communities:** The CDC's Healthy Communities Program has worked with more than 300 community coalitions to help create a culture of healthy living while building national networks for sustainable change. The Sustainability Planning Guide Provides evidence-based insights to help coalitions, public health professionals, and other community stakeholders develop, implement, and evaluate a successful sustainability plan. http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/pdf/sustainability_guide.pdf

Conclusion

This draft Guide v1.0 is the first step toward developing a practical handbook – which may become an online resource in the future – intended to be short and with links to more information and useful resources. It takes a broad look at the issue, without duplicating the great work already done by others. To help us refine this Guide, please provide comments on the questions below or any other issue.

1. Is this Guide easy to understand? What would make it better?

2. Are any changes needed in the ten essential elements?

3. Are the examples helpful? Is there a way to make them better?

4. Are the lists of resources useful? What would make them better?

5. Can you see a role for your organization in population health improvement? Do the actions suggested in this Guide align with your organization's goals and values?

Appendix A: Methodological Approach

This is the first draft version of the Guide, developed with the intention to gather input from the project Committee of experts and the public. The comments on the name and content of this document will be used to refine the draft and produce the first version of the Guide (version 1.0 or v1.0).

Assuming that the Department of Health and Human Services will continue to support this project into the second year, the Guide v1.0 will be shared with the project Committee of experts, the public, and selected groups engaged in population health improvement who volunteer to review, apply and help refine the Guide v1.0. The project team will regularly interact with these selected groups or "feedback communities" to learn from their implementation activities associated with the Guide v1.0. Requested input on the Guide v1.0 will focus on both the content and the format (e.g., written report with hyperlinks, online site, interactive application) drive modification of the Guide to be more specific and practical to drive actions at the local, state and national levels. The refinements will be included in the second version of the Guide (v2.0).

The third year of this project – assuming the continued support from the Department of Health and Human Services – will involve the development of the third and final version of the Guide (v3.0). During the year, various iterations will be shared with the project Committee of experts, the public, and the "feedback communities" to gather input on the content and format. This guidance will be used to finalize the Guide.

This draft Guide v1.0 builds on insights from the following sources:

- NQF Population Health Framework project, funded by the federal Department of Health and Human Services and led by a multi-stakeholder committee of experts providing guidance regarding the development of the *Action Guide*. For a summary of the project and a list of committee members, go to http://www.qualityforum.org/projects/population_health_framework/#t=1&s=&p=

- *Multi-stakeholder Input on a National Priority: Working with Communities to Improve Population Health. Environmental Scan and Analysis to Inform the Action Guide*, developed by a project team at NQF in 2013. This paper assessed key elements in conceptual frameworks in academic papers and articles, in addition to core aspects of programs being implemented at the local, state or national levels, to identify insights regarding potential content for the *Action Guide*.[23]

- *An Environmental Scan of Integrated Approaches for Defining and Measuring Total Population Health*,[24] commissioned by NQF in 2012. Jacobson and Teutsch established definitions for key

[23] StollenWerks Inc and NQF, *Environmental Scan and Analysis to Inform the Action Guide*, 2013. Available at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=74400

[24] Jacobson, DM and 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.

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.

Appendix B: Example Lists of Measures

Notes:

- The goal by the end of this project (Option Year two) is to have a recommended menu of measures to choose from, listed in the final Action Guide
- Feedback Communities will help identify the most useful measures

Questions:

1. **Of the measure list sources noted below:**
    a. **Which measure lists or measures are useful and easy to use, just as they are now (e.g., as *currently* structured, described, available, etc.)? Are you using any of them? If so, how are you using them?**
    b. **Which measure lists or specific measures *could be useful or easier to use* if they were changed in some way (e.g., structure, description, availability, frequency of updates)? Are you using those measure lists or specific measures? If so, how are you using them? If not, how would you like to use them?**
2. **What other measure lists or specific measures do you currently use? How do you use them?**
3. **What types of measures or measure lists would you like to access, but aren't sure where to find them or whether they exist? How would you like to use the measures?**

Sources for Lists of Measure Under Consideration for Inclusion in the Final Version of the Guide

A Healthier America 2013: Strategies to Move from Sick Care to Health Care in Four Years
The strategic paper suggests Public Health Accreditation Board (PHAB) accreditation standards in 12 domains: 10 essential public health services; management and administration; and governance.
http://healthyamericans.org/report/104/

Beacon Community Program
Program materials state that three general types of measures are used for quality measurement: structural (i.e., infrastructure elements, such as the presence or absence of an electronic health record), process (i.e., whether a recommended service was delivered), and outcome measures (i.e., aspects of health, such as cholesterol levels). However, specific measures are not listed.
http://www.healthit.gov/policy-researchers-implementers/beacon-community-program

The Blue Zones Project
Official "Blue Zones" communities are 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.
https://www.bluezonesproject.com

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 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

Correctional Health Outcomes and Records Data Set (CHORDS)
CHORDS is a clinical outcomes data sharing system being designed for correctional health care settings. The first nine performance measures, all related to diabetes, have been devised and the first test of the system has been conducted. However, information is not publicly available about specific measures.
http://www.ncchc.org/chords

County Health Rankings and Roadmaps
The County Health Rankings score communities according to a variety of health measures based on health outcomes and health factors, which are broken down into eight composite areas and then into subcomponent areas.
http://www.countyhealthrankings.org/app/home

Early Education Readiness Using a Results-Based Accountability Framework
A collaborative of parents and child-serving organizations in Los Angeles County worked together to establish a set of school readiness indicators. The workgroup 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 Los Angeles County: Good health; Safety and survival; Economic well being; Social and emotional well-being; and Education/workforce readiness.
http://www.first5la.org/files/ShapingtheFutureReport.pdf

Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost
This 2013 white paper from the Institute for Healthcare Improvement presents suggested measures for the three dimensions of the Triple Aim, accompanied by data sources and examples, with descriptions of how the measures might be used.
http://www.ihi.org/resources/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx

Healthy Communities Network (HCN)
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 database includes more than 75,000 quality of life indicators that are accessible based on a fee.
http://new.healthycommunitiesinstitute.com/healthy-communities-network-2/

Healthy Communities Data and Indicators Project (HCI)
In order to serve a goal of enhancing public health, this project includes the development of a standardized set of statistical measures for use in community health planning and assessment. A draft core list of indicators was developed in 2013 and more than 50 indicators are being vetted and constructed, with information on the impact, evidence, data sources, bibliographic references, and methods and limitations of each.
http://www.cdph.ca.gov/programs/Pages/HealthyCommunityIndicators.aspx

Healthy People 2020
Healthy People 2020 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. Four foundation 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, and measures are included for each.
http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx

Hennepin Health
This pilot program seeks to integrate medical, behavioral health, and human services in a patient-centered model of care. The program uses an integrated data warehouse and analytics infrastructure to support timely, actionable feedback to members, providers, and administrators and 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.
http://www.hennepin.us/healthcare

HHS Action Plan to Reduce Racial and Ethnic Disparities
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).
http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=285

Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014
This set of strategic initiatives for the Substance Abuse and Mental Health Services Administration (SAMHSA) provides goals, action steps and measures for determining success both internally and overall for population health improvement. Each of the eight strategies includes a set of measures for determining success.
http://store.samhsa.gov/shin/content/SMA11-4629/01-FullDocument.pdf

The National Service Frameworks
The National Service Frameworks (NSF) are a collection of strategies from the National Health Service in the U.K. to address the prevention and treatment of cancer, coronary heart disease, COPD, diabetes, kidney care, long-term conditions, mental health issues and stroke, as well as caring for the elderly and providing end of life care. Specific domains and measures are provided for each framework.
http://www.nhs.uk/nhsengland/NSF/pages/Nationalserviceframeworks.aspx

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. The tool covers a set of domains that includes measures spanning clinical care, demographics, environment and social characteristics.
http://clfuture.org/atlas-map-series/demographics

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

Appendix C: Example Lists of Data Sources

Notes:

- The goal by the end of this project (Option Year two) is to get input on key federal data sources (credibility of methodology, desired uses and whether the age / recency of the data is an issue, understandability)
- Feedback Communities will help identify the most useful data sources

Questions:

1. **Of the data sources listed below:**
    a. **Which data sources are useful and easy to use, just as they are now (e.g., as *currently* structured, described, available, etc.)? Are you using those data sources? If so, how are you using them?**
    b. **Which data sources *could be useful or easier to use* if they were changed in some way (e.g., structure, description, availability, frequency of updates)? Are you using those data sources? If so, how are you using them? If not, how would you like to use them?**
2. **What other data sources do you currently use? How do you use them?**
3. **What types of data would you like to access, but aren't sure where to find it or whether it exists? How would you like to use that type of data?**

Data Sources Under Consideration for Inclusion in the Final Version of the Guide

Center for Vital Statistics Health Data Interactive
This resource presents tables with national health statistics for infants, children, adolescents, adults, and older adults. Tables can be customized by age, gender, race/ethnicity, and geographic location to explore different trends and patterns.
http://www.cdc.gov/nchs/hdi.htm#tutorials

Behavioral Risk Factor Surveillance System (BRFSS)
BRFSS is an on-going telephone health survey system focused on collecting behavioral health risk data. The annual survey data is published online and used by the Centers for Disease Control and Prevention (CDC) and other federal agencies.
http://www.cdc.gov/brfss/about/index.htm

Correctional Health Outcomes and Records Data Set (CHORDS)
CHORDS is a clinical outcomes data sharing system being designed for correctional health care settings. Data is supplied by jails and other correctional facilities. For example, the first measures, data were submitted by 66 participants—56 prisons and 10 jails; of these, 59 were single-site entities.
http://www.ncchc.org/chords

County Health Rankings and Roadmaps
The County Health Rankings score communities according to a variety of health measures based on health outcomes and health factors, which are broken down into eight composite areas and then into subcomponent areas.
http://www.countyhealthrankings.org/app/home

Data.Gov
The U.S. government's data portal provides access to federal, state and local data, as well as tools, research resources and more. The "Health" section includes 1,125 data sets, tools and applications related to health and health care and can be used as a resource for groups or individuals looking for examples of data or actual data sets for reporting purposes.
https://www.data.gov/health/

Data.CDC.Gov
This online database provides access to data sources from the Centers for Disease Control and Prevention (CDC).
https://data.cdc.gov/

National Institutes of Health (NIH) Data Sharing Repository
The National Library of Medicine (NLM) website provides a table of NIH-supported data repositories that accept submissions of appropriate data from NIH-funded investigators (and others). Also included are resources that aggregate information about biomedical data and information sharing systems.
http://www.nlm.nih.gov/NIHbmic/nih_data_sharing_repositories.html

Appendix D: Example Lists of Tools

Notes:

- By end of this project (Option Year two) the Action Guide may be an online resource. The range of possible tools is extremely broad.
- Feedback Communities will help identify the most useful tools

Questions:

1. **Of the resources or tools listed below:**
    a. **Which resources or tools are useful and easy to use, just as they are now (e.g., as *currently* structured, described, available, etc.)? Are you using any of them? If so, how are you using them?**
    b. **Which resources or tools *could be useful or easier to use* if they were changed in some way (e.g., structure, description, availability, frequency of updates)? Are you using any of them? If so, how are you using them? If not, how would you like to use them?**
2. **What other resources or tools do you currently use? How do you use them?**
3. **What types of resources or tools would you like to access, but aren't sure where to find them or whether they exists? How would you like to use them?**

Resources or Tools Under Consideration for Inclusion in the Final Version of the Guide

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. 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.
http://www.assesstoolkit.org/

The Blue Zones Project
The Blue Zones Project focuses on encouraging individuals and community members to aspire to healthy lifestyle ideals, which are based on research into communities around the world with the highest number of centenarians. 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.
https://www.bluezonesproject.com/

Camden Care Management Program and Cross-Site Learning
This program through the Camden Coalition of Healthcare Providers includes development of 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 ten cities. Tools, planning guides and other materials are being provided to expand "hot spotting" to other locations.
http://www.camdenhealth.org/cross-site-learning/

County Health Rankings and Roadmaps
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 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.
http://www.countyhealthrankings.org/

Family Wellness Warriors Initiative
This anti-domestic violence initiative holds multi-day trainings to educate "natural helpers" and community members on how to work with people affected by violence, reduce abuse in the community and implement the program's anti-violence curriculum. The program's website also includes a map with localized resources, such as counseling centers, for violence and abuse prevention.
http://www.fwwi.org/index.cfm

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, blog and social networking account to facilitate the sharing of best practices and resources. The resources page also lists tools for 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.
http://www2.ed.gov/about/inits/ed/green-strides/resources.html#topic2

The Guide to Community Preventive Services
The Guide to Community Preventive Services is a free resource to help identify programs and policies to improve health and prevent disease in the community, based on recommendations from the Community Preventive Services Task Force.
http://www.thecommunityguide.org/index.html

Healthy Communities Network (HCN)
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 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. 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.
http://new.healthycommunitiesinstitute.com/healthy-communities-network-2/

Health in All Policies: A Guide for State and Local Governments
The Health in All Policies guide includes "Food for Thought" questions in each section that leaders of a Health in All Policies initiative are encouraged to consider. The guide also includes tips for identifying new partners, building meaningful collaborative relationships across sectors, and maintaining those partnerships over time, as well as more than 50 annotated resources for additional support.
http://www.phi.org/resources/?resource=hiapguide

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, 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. These materials are not currently available online, but only through participation in the program and outreach sites.
http://www.uwbec.org/content/pages/wellness10

Let's Move
Online resources from the Let's Move initiative include "5 simple steps" guides for parents, schools, community leaders, chefs, children, elected officials and health care 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/action

Moving Healthy
This overview of the health-related strategies being explored by the U.S. Department of Transportation Federal Highway Administration (FHWA) references various tools, including resources created by FHWA that are intended to help both transportation professionals and health practitioners identify and address the health impacts of transportation.
https://www.fhwa.dot.gov/planning/health_in_transportation/resources/moving_healthy.cfm

The National Prevention Strategy
The Surgeon General's website for this national initiative features various resources related to the National Prevention Strategy, including fact sheets, infographics, implementation resources and scientific resources.
http://www.surgeongeneral.gov/initiatives/prevention/resources/index.html

The National Service Frameworks
The National Service Frameworks (NSF) are a collection of strategies from the National Health Service (NHS) in the U.K. to address the prevention and treatment of cancer, coronary heart disease, COPD, diabetes, kidney care, long-term conditions, mental health issues and stroke, as well as caring for the

elderly and providing end of life care. The webpages for each framework include educational materials and links to additional resources, such as non-profit organizations and further information within the NHS.
http://www.nhs.uk/nhsengland/NSF/pages/Nationalserviceframeworks.aspx

One in 21 Muskegon County
This is the umbrella program for local initiatives like "Project Healthy Grad" and includes a list of resources on its website that includes educational information as well as links to local farmers' markets and other local resources for Muskegon County, Michigan.
http://1in21.org/resources

Operation Live Well
This initiative aimed at improving the health of military personnel and their families includes a website with resources related to the focus areas of the program and preventive health, in addition to a list of health tools from various organizations.
http://www.health.mil/livewell

Practical Playbook
This resource for public health and primary care groups features an interactive tool that guides users through the stages of integration for population health improvement projects. Note: The Practical Playbook website, including the interactive tool, is currently under construction and is set to re-launch "in early 2014."
http://www.practicalplaybook.org/

Regional Equity Atlas 2.0 and Action Agenda
This research and education project includes maps the Portland metro region using data on chronic disease prevalence as well as social, economic, and physical determinants of health, and provides insight into key findings. A web-based mapping tool allows for customized creation of maps on key issues affecting the region, and technical training and equity analysis workshops are offered to local organizations.
https://clfuture.org/equity-atlas

Shaping the Future Report
The Shaping the Future Report presents school readiness goals and indicators to guide planning and accountability around children's readiness for school in Los Angeles County. The tool was created to engage community stakeholders, monitor trends, and implement a results-based accountability framework.
http://www.first5la.org/research/shaping-the-future-report

The Substance Abuse and Mental Health Services Administration (SAMHSA)
SAMHSA's website provides resources and guidance on substance abuse, 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, education and informational materials and links to external organizations.
http://www.samhsa.gov/

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. Community tools offered through the initiative include healthier living workshops and tobacco cessation workshops, in addition to supporting educational materials and guidance on how to implement the Blueprint.
http://hcr.vermont.gov/blueprint

YMCA Healthier Communities Initiatives

The YMCA provides various resources for promoting healthier communities, including a guide on linking policy and environmental strategies to health outcomes and the Community Health Living Index (CHLI), which contains self-assessments for six key community settings and provides best practices to promote improvement.
http://www.ymca.net/healthier-communities

Appendix E: 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

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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
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New Hampshire Department of Health and Human Services, Concord, NH

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David B. Nash, MD, MBA
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David Stevens, MD
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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

Appendix F: Project Staff

National Quality Forum Staff

Karen Adams, PhD, MT
Vice President, Strategic Partnerships

Elizabeth Carey, MPP
Project Manager, Strategic Partnerships

Allen Leavens, MD, MPH
Senior Director, Strategic Partnerships

Elisa Munthali, MPH
Managing Director, Performance Measurement

Zehra Shahab, MPH
Project Analyst, Performance Measurement

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NATIONAL QUALITY FORUM

Roster & Biographies

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

Committee Roster

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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

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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.

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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

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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.

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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

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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.