NATIONAL QUALITY FORUM

Agenda

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

Public Web Meeting

Thursday, May 1, 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 **496111** 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 **34198007**.

Public Participant

- Dial **1-866-309-3375** and use confirmation code **34198007**.

Meeting Materials:

- Agenda
- PowerPoint
- Chart of Public Comments
- Committee roster and bios

Meeting Objectives:

- Review major themes from the public commenting period on the Community Action Guide; and
- Discuss comments requiring further guidance from the Committee.

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

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

12:05 pm **Opening Remarks**

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

12:10 pm **Project Overview & Interconnections to Population Health Initiatives across NQF**

Bruce Siegel, MD, MPH (Co-Chair)

12:20 pm **Overarching Themes from Public Comment on the Community Action Guide**

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

- Clustering of major public comment themes
  - General feedback
  - Suggestions for specific clarifications or revision
  - Suggestions for changes to format or structure
  - Additional suggested resources and case examples/vignettes
- High-level reactions from committee on major themes

12:35 pm **Public Comment**

12:40 pm **Committee Strategic Discussion**

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

- Unique value of the Action Guide and alignment with other efforts
- Inclusion of specific subpopulations

1:45 pm **Public Comment**

1:55 pm **Next Steps**

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

- Planning for June In-Person Meeting:
  - Final review of draft *Community Action Guide*
  - Planning for Project Year 2: Feedback Communities

2:00 pm **Adjourn**

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

NATIONAL QUALITY FORUM

Public Web Meeting

May 1, 2014

#NQFPopHealth

1

Welcome & Meeting Objectives

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

NATIONAL QUALITY FORUM

2

Agenda at a Glance

- Welcome & Meeting Objectives
- Opening Remarks
- Project Overview & Interconnections to Population Health Initiatives across NQF
- Overarching Themes from Public Comment on the Community Action Guide
- Public Comment
- Committee Strategic Discussion
- Public Comment
- Next Steps

Meeting Objectives

- Review major themes from the public commenting period on the Community Action Guide; and
- Discuss comments requiring further guidance from the Committee.

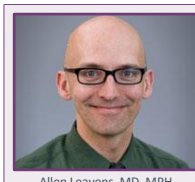
Project Staff

Karen Adams, PhD, MT

Vice President, Strategic Partnerships

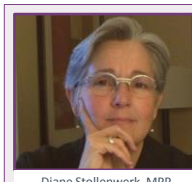
Elisa Munthali, MPH

Managing Director, Performance Measurement



Allen Leavens, MD, MPH

Senior Director, Strategic Partnerships



Diane Stollenwerk, MPP

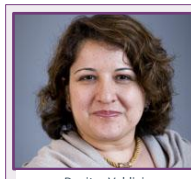
Consultant

Beth Carey, MPP

Project Manager, Strategic Partnerships

Zehra Shahab, MPH

Project Analyst, Performance Measurement



Danitza Valdivia

Administrative Manager, Strategic Partnerships

NATIONAL QUALITY FORUM 5

Opening Remarks

Nancy Wilson, MD, Government Task Lead, AHRQ

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

NATIONAL QUALITY FORUM 6

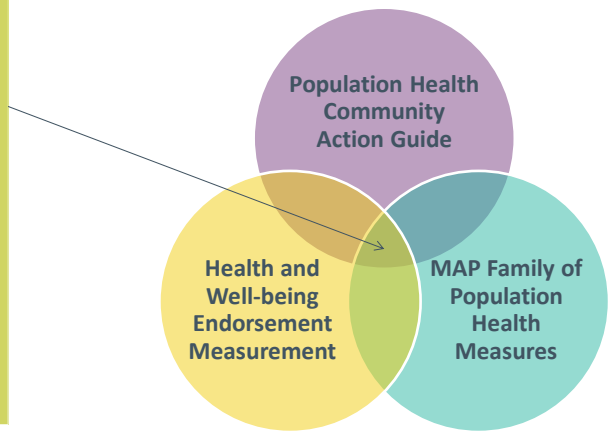
Project Overview & Interconnections to Population Health Initiatives across NQF

Bruce Siegel, MD, MPH (Co-Chair)

National Quality Strategy

NQF's Current Work on Population Health

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



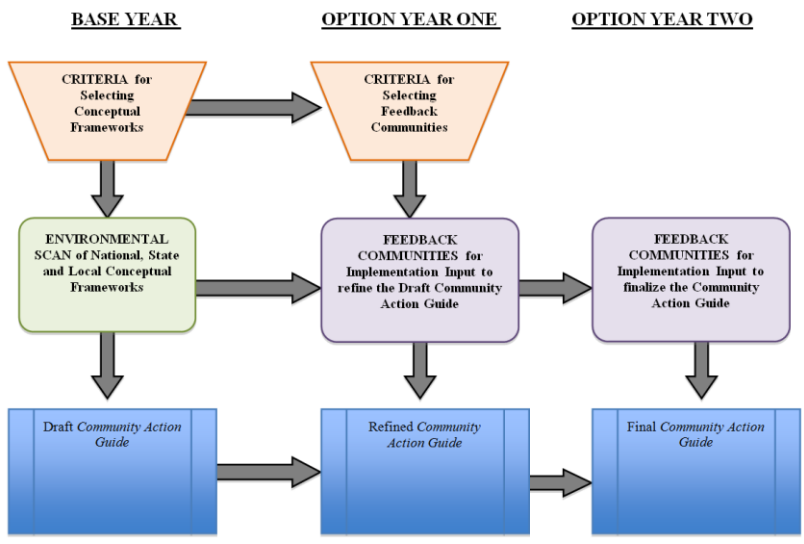
NATIONAL QUALITY FORUM 9

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

NATIONAL QUALITY FORUM 10

Starting with the End in Mind: Connections across Project Deliverables



NATIO

Overarching Themes from Public Comment

Moderator: Kaye Bender

NATIONAL QUALITY FORUM 12

Overview of Public Response

- Clustering of Major Public Comment Themes
  - General feedback
  - Suggestions for specific clarifications or revision
  - Suggestions for changes to format or structure
  - Additional suggested resources and case examples/vignettes
- High-level reactions from committee on major themes

Public Comment

Committee Strategic Discussion

Moderator: Bruce Siegel

Themes Requiring Further Committee Guidance

- Unique value of the Community Action Guide and alignment with other efforts
  - There are a number of tools and compendia of resources developed to assist organizations in their efforts to improve population health.
  - Is the Action Guide achieving the goal of adding value to existing efforts on improving population health?

Themes Requiring Further Committee Guidance

- Inclusion of specific subpopulations
  - Is it feasible to provide an exhaustive list of all subpopulations in the Guide given their breadth and diversity?
  - How much should the Guide try to address specific subpopulations and address their relevant issues, such as health disparities?
  - Is it important to call out the need for measures, data, and tools for specific subpopulations?

Public Comment

Next Steps

Elizabeth Carey, Project Manager, NQF

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

- In-Person Committee Meeting: June 10-11, 2014 at NQF Offices, Washington, DC
  - Final review of *Community Action Guide 1.0*
  - Planning for Project Year 2: Feedback Communities

Date of Comment	Comment Submitter Name	Comment Submitter Organization	Question	Comment
Apr 15 2014 2:36PM	Koryn Rubin	American Medical Association	Are there any changes you would recommend to the lists of resources to make them more practical for the work you are doing? (Please see Appendices B, C, and D.)	When dealing with younger populations, we suggest the YRBS (Youth Risk Behavior Survey), where available, as an added resource.
Apr 15 2014 4:55PM	Marice Ashe	ChangeLab Solutions	Are there any changes you would recommend to the lists of resources to make them more practical for the work you are doing? (Please see Appendices B, C, and D.)	There are dozens of model public health policies, how-to guides, fact sheets and webinars concerning policies related to chronic disease control and Health in All Policies available for free download on the ChangeLab Solutions website (www.changelabsolutions.org). These peer-reviewed resources have been developed with funding and approval from the Centers for Disease Control, the Robert Wood Johnson Foundation, the State of California Tobacco Control Program, and other reputable and credible public health leadership organizations and agencies.
Apr 16 2014 11:59AM	Shawn Terrell	Administration for Commuity Living	Are there any changes you would recommend to the lists of resources to make them more practical for the work you are doing? (Please see Appendices B, C, and D.)	Include a few examples of measurement instruments that address community living experiences and quality of life outcomes among people with disabilites across the lifespan (e.g. the National Core Indicators: available in 36 states for the ID/DD population.)
Apr 15 2014 3:39PM	Christine Pozar	Highmark	Are there any changes you would recommend to the lists of resources to make them more practical for the work you are doing? (Please see Appendices B, C, and D.)	A crosswalk that includes the measures, data analysis resources, and tools as an overview with more detailed information following.
Apr 16 2014	Ruth Greenslade, MPP	Goodhue County Health and Human Services	Are there any changes you would recommend to the lists of resources to make them more practical for the work you are doing? (Please see Appendices B, C, and D.)	Appendix B—could you start the section with a table listing just the name of the measures, hyperlinked? It could hyperlink you right to their site. Then below you could still have the short paragraph about each, but it would be neat to have a table up top listing them all. Appendix C—could you add America's health rankings www.americashealthrankings.org, Community Need Index Scores http://cni.chw-interactive.org/, Measure of America www.measureofamerica.org/data-table-download/? Or would they better fit under Appendix B or D?
Apr 15 2014 8:47PM	Erik Halaas	YMCA of San Francisco	Are there any changes you would recommend to the lists of resources to make them more practical for the work you are doing? (Please see Appendices B, C, and D.)	Having this as a web-based resource would allow for real-time updates and ensure the resources are relevant and up to date. It could also serve as a web-community of sorts to provide platforms for more localized or targeted resources (e.g. pages with data sources at the neighborhood, ZIP, PUMA, city, etc., levels or specific to certain demographics, health issue areas, etc.). Space to comment, share resources, pose questions, and more would allow people to address needs that may fall outside the scope of a one-size-fits-all action guide.
Apr 16 2014 2:57PM	Julia Elligers	NACCHO	Are there any changes you would recommend to the lists of resources to make them more practical for the work you are doing? (Please see Appendices B, C, and D.)	This action guide seems more like a compilation of resources than a practical guidebook for planning and implementation. Based on NACCHO's experience, local health departments are overwhelmed by long lists of resources that do not inlcude guidance on how to pick which ones would work for them.
Apr 14 2014 11:04AM	Donna Nichols	Directors of Health Promotion and Education	Are there any changes you would recommend to the lists of resources to make them more practical for the work you are doing? (Please see Appendices B, C, and D.)	To keep this document current and relevant, resources and text will need to be updated at regular intervals; otherwise, this document will lose its appeal and relevance.
Apr 7 2014 2:33PM	Sarah Bergman	Allina Health	Are there any changes you would recommend to the lists of resources to make them more practical for the work you are doing? (Please see Appendices B, C, and D.)	Some of the resources are listed multiple times within the document. To make it more concise, I would consider just listing them each once.
Apr 16 2014 2:58PM	Julia Elligers	NACCHO	Do the actions suggested in this Guide align with your organization's goals and values? Why or why not?	As indicated by NACCHO's comments to the previous questions, the actions in this guide do not align with NACCHO's health equity approach or how it values community engagement and community-owned improvement processes.

Date of Comment	Comment Submitter Name	Comment Submitter Organization	Question	Comment
Apr 16 2014 3:40PM	Alan Parver	Healthcare Nutrition Council	Do the actions suggested in this Guide align with your organization's goals and values? Why or why not?	The actions proposed in the Guide align with the goals and values of the Healthcare Nutrition Council (HNC). HNC is a group of medical nutrition manufacturers working together to improve the public's nutritional health by advancing awareness of malnutrition and its impact on health care costs and patient outcomes; promoting routine nutritional screening, assessment, and appropriate nutritional clinical interventions; and protecting patients' access to enteral and parenteral nutrition throughout the continuum of care. HNC supports NQF's work to establish a handbook for stakeholders to use to promote and improve population health. We support NQF's interest in considering for endorsement a population-level measure on nutrition and diet. We also commend NQF for including in the Guide a root-cause map for obesity as an example of how to identify priority health improvement activities, and for suggesting that one activity include "Hospitals, doctors and nurses measuring the body mass index of every patient and, where needed, discussing ideas for better nutrition and adding physical activity." While this recommendation falls short of full nutrition screening, we believe that this is a step in the right direction. Nonetheless, we encourage NQF to remind stakeholders that patients may be malnourished regardless of BMI as they may be deficient in the macro and micro nutrients needed to help promote healing and reduce medical complications. In fact, people who are overweight can be malnourished or at risk for malnutrition, and may benefit from intensive nutrition intervention. As NQF continues to develop and update the Guide, HNC encourages NQF to urge organizations and individuals working to improve population health to focus on identifying, preventing and treating disease-related malnutrition in a timely manner. Regularly screening and assessing patients for malnutrition and providing appropriate nutritional interventions can improve patients' nutritional status and contribute to improved population health. As a result of detecting, preventing and treating disease-related malnutrition, individuals will experience less morbidity and fewer complications, shorter hospital stays, and fewer hospitalizations and hospital readmission. Thus, HNC encourages NQF to consider endorsing a measure that promotes routine nutrition screening, assessment and appropriate nutrition intervention. References available upon request.
Apr 15 2014 4:55PM	Marice Ashe	ChangeLab Solutions	Do the actions suggested in this Guide align with your organization's goals and values? Why or why not?	Yes, very much so. But, the Guide would align even more fully if it explicitly embraced and prepared state and local leaders to be successful public policy change agents.
Apr 14 2014 11:09AM	Donna Nichols	Directors of Health Promotion and Education	Do the actions suggested in this Guide align with your organization's goals and values? Why or why not?	DHPE recommends you revise the very FIRST sentence in the document. Avoid using "health care" in the opening sentence since you are trying to distinguish the difference between health and health care in the 3rd paragraph. Use "health improvement" instead of "health care." DHPE's mission aligns closely with the actions of this Guide. Our work supports population health in states and localities. See www.dhpe.org
Apr 15 2014 3:41PM	Christine Pozar	Highmark	Do the actions suggested in this Guide align with your organization's goals and values? Why or why not?	They do. Making the connections with various departmental staff and the appropriate community based leader is more difficult to identify. Perhaps a leadership guide with an algorithm of departments/organizations to contact would be helpful.

Date of Comment	Comment Submitter Name	Comment Submitter Organization	Question	Comment
Apr 16 2014 2:36PM	Penelope Solis	American Heart Association	Do the actions suggested in this Guide align with your organization's goals and values? Why or why not?	The American Heart Association wishes to commend NQF on this guide as a resource designed to help communities initiate or improve population health programs. If the AHA can be of assistance in dissemination among community leaders and advocates, health systems leaders and workforce, thought leaders and implementers in medical care system reform (ACOs and PCMHs) for example, policy makers, local and state health department leaders and workers, and the lay public. Concrete examples in the different sections are very helpful to readers at any level of expertise and interest. The guide lines up with the AHA goal to improve the cardiovascular health in all Americans by 20% by 2020. The AHA has identified no smoking, healthy eating, regular physical activity, and healthy weight, blood pressure, cholesterol, and blood glucose as the factors that contribute to ideal cardiovascular health. The AHA believes that will happen by assuring high quality medical care for CVD and stroke and assuring the conditions in communities that make ideal CV health possible from access to healthy, affordable food and physical activity to smoke-free communities. The guide could be used in a variety of ways in different communities to develop plans that would help the AHA reach its 2020 goals. It provides an outline for the types of things communities need to do to improve public health broadly. The guide may serve as a bridging platform to increase communication between the medical care delivery system with others in the health promotion and disease prevention sector. It will be helpful to make sure that public health leaders and workers know that this document exists. The public health community might not be looking for a document like this to be coming forward from NQF. The AHA acknowledges the names and obvious contributions of several outstanding "public health people" on the writing group, and their involvement is obvious. The AHA wants to make the following reference for your consideration: AHA Community Guide addresses some of the same issues, and the tables may be helpful. American Heart Association Guide for Improving Cardiovascular Health at the Community Level, 2013 update: a scientific statement for public health practitioners, healthcare providers, and health policy makers.<http://www.ncbi.nlm.nih.gov/pubmed/23519758> Pearson TA, Palaniappan LP, Artinian NT, Carnethon MR, Criqui MH, Daniels SR, Fonarow GC, Fortmann SP, Franklin BA, Galloway JM, Goff DC Jr, Heath GW, Frank AT, Kris-Etherton PM, Labarthe DR, Murabito JM, Sacco RL, Sasson C, Turner MB; American Heart Association Council on Epidemiology and Prevention. Circulation. 2013 Apr 23;127(16):1730-53. doi:
Apr 7 2014 2:33PM	Sarah Bergman	Allina Health	Do the actions suggested in this Guide align with your organization's goals and values? Why or why not?	Yes. There is a focus on community and collaboration.
Apr 15 2014 2:36PM	Koryn Rubin	American Medical Association	Do the actions suggested in this Guide align with your organization's goals and values? Why or why not?	Yes, the American Medical Association has a long history of promoting not only scientific advancement and investment in the doctor and patient relationship, but improved public health and a new strategic focus on improved health outcomes from a population health perspective.
Apr 15 2014 8:47PM	Erik Halaas	YMCA of San Francisco	Do the actions suggested in this Guide align with your organization's goals and values? Why or why not?	Yes, the YMCA of San Francisco is currently building out our strategic plan in support of our 2020 vision that the Healthiest Kids in America will live in the Bay Area, building the skills and habits for a healthy life, enabling them to reach their highest potential through the strength of the communities we serve. The concept of collective impact is a foundational element of our efforts and the 10 elements referenced through this action guide are very much aligned with our approach. Moreover, as a longstanding community stronghold with a presence throughout the U.S. and abroad, the Y is uniquely positioned to play an active role in supporting positive changes in population health; a [potential that surely multiplies when implemented within a cross-sector collaborative. While this is commonly understood among various organizational leaders and staff, a clear and concise Action Guide could prove tremendously helpful in strengthening both internal and external capacity and messaging in driving our efforts to support positive change in population health.
Apr 16 2014 3:01PM	Deborah Fritz	GlaxoSmithKline	Do the actions suggested in this Guide align with your organization's goals and values? Why or why not?	GSK applauds the efforts of NQF's Population Framework Committee to develop the Community Action Guide that acts as a practical guidance for improving population health. Especially notable in the document is the applicability of the resource to those of different experience levels in undertaking population health initiatives, as well as guidance to resources for reference. The specific notation of access to preventive services for health improvement activity such as immunizations, weight loss intervention, and smoking cessation is particularly noteworthy as examples of topics relevant to a broad array of stakeholders. The work of this Committee and the Guide align with GSK's goals and values particularly putting the "patient first" and access to preventive services.
Apr 16 2014 5:15PM	Britta Orr	Local Public Health Association of Minnesota	Do the actions suggested in this Guide align with your organization's goals and values? Why or why not?	Yes!

Date of Comment	Comment Submitter Name	Comment Submitter Organization	Question	Comment
Apr 16 2014 12:00PM	Shawn Terrell	Administration for Commuity Living	Do the actions suggested in this Guide align with your organization's goals and values? Why or why not?	Yes. There has been a great deal of policy activity in the HCBS world over the last three months with the publication of the final HCBS rules by CMS, and active engagement of staff with HCBS expertise in many of the current NQF workgroups. The HCBS regulations represents an historic shift in how CMS (and by extension much of the rest of HHS) view what community integration means for people with disabilities. This shift moves policy toward an affirmative statement of what is meant by community living and that individually defined quality of life is foundational. This policy shift has exposed a fundamental need for the application of quality measures at the individual, population, and systemic levels. We believe the principles embodied in the population health Action Guide could be employed to greatly assist in the implementation of this new HCBS perspective.
Apr 16 2014	Ruth Greenslade, MPP	Goodhue County Health and Human Services	Do the actions suggested in this Guide align with your organization's goals and values? Why or why not?	Yes, I think so.
Apr 7 2014	Mary Kushion	Mary Kushion Consulting, LLC	General Comments	10. Element 7 has just one sentence that references the importance of communication with the coalition group. The rest of the element's guidance appears to be geared towards how to effectively communicate messages outward and into the community. I recommend at least one resource be provided on effectively communicating within the coalition. I am certain there are volumes available and would be happy to explore upon request. 11. The Guide does not mention "collective impact" anywhere in the document. This is an important concept and I recommend it be cited as a reference somewhere in the Guide.
Apr 15 2014	Clarke Ross, D.P.A	American Association on Health and Disability	General Comments	Dear friends and colleagues at the National Quality Forum: Following the April 9 meeting of the NQF MAP population health task force, on behalf of the American Association on Health and Disability (AAHD), I submit the following suggested additions to Improving Population Health by Working with Communities - Action Guide 1.0 - April 2 draft. The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities. These comments are shared with the Consortium for Citizens with Disabilities (CCD) task forces on health and long-term services and supports leadership. These comments are shared with the staff leadership of Mental Health America. The Importance of Person Centeredness and Patient/Consumer/Person Engagement in a Population Health Paradigm and in the Community Action Guide The April 9 MAP population health task force discussed the importance of including person centeredness and patient/consumer/person engagement in a population health paradigm. Clarke provided examples of person engagement related to disability: National Core Indicators; Council for Quality and Leadership personal outcome measures; chronic disease self-management programs; peer wellness and peer support in the area of mental illness and disability; centers for independent living focus on self-direction and empowerment; Medicaid cash and counseling program; and Medicaid HCBS experience survey and relation to CAHPS. The theme of person centeredness is important to multiple NQF entities. The Importance of Home and Community Living as a Population Health and Community Action Guide Topic Consistent with the Olmstead Supreme Court decision and the work of the NQF workgroup on persons dually eligible for Medicare and Medicaid, please include home and community living as an area of emphasis in the community action guide. Home and
Apr 16 2014	Vickie Boothe, MPH	Office of Public Health Scientific Services Centers for Disease Control and Prevention	General Comments	5. Page 22 "Section: Element 4: A Community Health Needs Assessment and Asset Mapping Process", I did not see anything in this section regarding the engagement of the actual community members to understand what their perceptions and priorities are. Based on the CHA literature, we identify the following 4 products as important inputs into the priority setting process: ☐ Secondary data analysis • Compare outcome and determinant indicators against peer communities, national averages, HP 2020 benchmarks) • Examine trends • Identify the most prevalent, severe and important subset of health outcomes and determinants ☐ Assessment of health disparities • Examine secondary data by sex, race/ethnicity, SES, and geography ☐ Community opinions • Primary data (qualitative and quantitative) • Collected through key interviews, town halls, listening sessions, and surveys • Identify community's prioritized set of outcomes and determinants ☐ Assets of the Health System and Community

Date of Comment	Comment Submitter Name	Comment Submitter Organization	Question	Comment
Apr 7 2014	Mary Kushion	Mary Kushion Consulting, LLC	General Comments	Thank you for the opportunity to review and provide comment on the proposed Guide. Overall, I believe the Guide will be another beneficial resource for local, regional, state groups who are engaging in population health improvement activities. I appreciate that the Guide was kept intentionally brief, but concise. My comments are shared from the perspective of someone who has not only conducted health improvement activities, but who has also had the opportunity to both advise and review the work of others in an effort to improve their work. The Guide, in its final form will undoubtedly be a valuable resource available to people such as myself and those engaged in this important work. The recommendations that follow are provided in the spirit of making the Guide useful to those who will want to use it. 1. The Guide provides a "checklist" on Page 12. The list contains the 10 elements for improving population health. However, it isn't displayed as a checklist, but rather as a reference which, according to the text preceding it, is the intent. I recommend that the Guide be revised to provide an actual checklist that can be utilized during the self-assessment process. I like the descriptions provided for each element (provided on page 14) and recommend they also be included in the checklist. Perhaps a checklist template could be provided in an appendix. 2. At the bottom of page 14 is a critically important sentence that many may overlook (I did the first time I read through the document). It states "After completing the self-assessment, the rest of the elements do not need to be followed in order." I recommend this sentence be put in bold text to alert the user of this important point or create a new section that starts with this sentence and then provide the example that is given.
Apr 15 2014	Candy Hadsall, RN, MA	Minnesota Department of Health	General Comments	I have reviewed some parts of the Guide although I admit I have not read through everything – I just received a copy today. My overall comment is that much of it is good, however, it seems clear to me that the process you have created is another way for health professionals to create actions they/we think should be accomplished, without soliciting community input FIRST. This is the way that health professionals have worked for decades, and with varying success – create plans and then seek community input on those ideas. Sometimes that works and sometimes we don't accomplish what we intended. Many times the professionals creating the ideas are European American in positions of power at various levels with lots of data at their disposal and years of training who attempt to figure out what they think a community needs. We always think we are "right" because we use lots of data to support our ideas and actions. Unconsciously we are supporting the dominant ways of thinking that
Apr 16 2014	Vickie Boothe, MPH	Office of Public Health Scientific Services Centers for Disease Control and Prevention	General Comments	2. Page 14 relating to the paragraph, "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." We are a little confused regarding how the term "asset" is being used here. According to some of the Community Health Assessment literature, we understood the term assets to be as follows with respect to population health improvement at the community level: "Assets are the strengths and resources of the individuals, associations, institutions, natural resources, physical structures, and informal organization in the community that can be utilized to address identified health needs (Berkowitz and Wadud 2003). The underlying philosophy of this activity is that although communities may have a multitude of health issues and disparities, they also have the ability and often underutilized resources to address these issues. The process of asset mapping can lead community members to become more empowered to work together. "Identifying and mobilizing community assets enable community members to become active shapers of their own destinies, instead of passive clients receiving services from a variety of agencies" (KC Community Tool Box). 3. Page 15, I just wanted to bring your attention to a newly redesigned resource of the Community Health Status Indicators which is scheduled to be launched by CDC this summer. I am attaching a 1-page Fact Sheet with the comments which will provide more detail. 4. Page 18, Another valuable resource for community coalitions is the CDC/ATSDR Principles of Community Engagement Second Edition located at http://www.cdc.gov/phppo/pce/

Date of Comment	Comment Submitter Name	Comment Submitter Organization	Question	Comment
Apr 12 2014	Bridget Catlin	County Health Rankings & Roadmaps	General Comments	Dear Diane, Thank you for bringing this to my attention. I had just recently learned of this important piece of work. I have some very specific comments that didn't seem to fit with the online comment section, and so I am sending them to you directly. On page 15, our project is incorrectly named: It says "Community Health Rankings and Roadmaps" and should say "County Health Rankings & Roadmaps." To properly acknowledge our funder and collaborator, please also add "a Robert Wood Johnson Foundation program" after our program name. In terms of what section of our site you refer to here, might I suggest that you refer to our home page (www.countyhealthrankings.org), rather to our specific tools on assessing needs and resources. On page 22, the current link County Health Rankings and Roadmaps link goes to our home page. Perhaps instead here, as you do above on page 15, you might want to link to the guidance that we offer that is specific to the current element. In this case, this
Apr 7 2014	Mary Kushion	Mary Kushion Consulting, LLC	General Comments	3. Page 18 lists the additional resources available for leadership/stakeholders. The County Health Rankings and Roadmaps (referenced in Element 1) have their great visual of the stakeholders included in their Roadmaps to Health Action Cycle. I recommend that it be included as a resource in Element 2. 4. Page 20 references a NACCHO brief – I recommend a hyperlink to the brief be embedded in the document in addition to the footnote. 5. Page 21 – the MAPP resource is better suited as a resource in Element 4 which focusses on the community health assessment process. 6. Page 22 – I recommend adding the Public Health Quality Improvement Exchange (www.phqix.org) as a resource. This website provides several examples of population health quality improvement activities and seems to fit with the other QI resources provided. 7. Page 24 – I recommend adding the Together We Can website as an example of how it is done. www.Together-We-Can.org. 8. Glad to see the inclusion of the Practical Playbook on page 25 and other places within the document. 9. Element 6 (Page 31 – How it Can be Done with Examples) contains the sentence "A helpful resource that may offer guidance will be available in June 2014 when the Institute of Medicine is expected to release a report with a core set of high-level measures for population health improvement." I am not aware of when the Guide will be produced in its final form, but June 2014 is coming up quickly and the IOM measures may be available prior to the release of the Guide. I recommend flagging this sentence and re-working it to reference the measures and then providing the link to them in the Resources section for this element. The current IOM measures are referenced and linked on page 46 (Appendix B) – is this list going to be updated? Again, recommend it is up-to-date prior to Guide publication.
Apr 15 2014	Julie Trocchio	CHA	General Comments	Thank you for including a link to CHA's resource "Assessing and Addressing Community Health Needs". If you would like a shorter URL to include in the guide you could use "www.chausa.org/assessplanresources" Page 5. This section asks to prioritize health improvement activities, strategies and action. As mentioned earlier, prioritization of needs must come first, and that cannot occur until needs are assessed. Page 28 Bluezones is an odd addition here. I went to their website and did not find it helpful. Pages 31 – 33 Will guide eventually give resources for these indicators, how to find in your community? That would be very useful. Page 37: Can add Healthy Communities Institute: their progress visuals are great Page 39, Again, don't see relevance of corrections
Apr 15 2014	Julie Trocchio	CHA	General Comments	3. Many resources are redundant, are listed several times. Also, some do not seem very useful to a community group doing a community health needs assessment project. Suggest going through each one with an eye on what is most useful.
Apr 15 2014	Julie Trocchio	CHA	General Comments	4. Yes, consistent with our goals and values. However, CHA would put more emphasis on looking at vulnerable populations.

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Apr 15 2014	Julie Trocchio	CHA	General Comments	Page 15: The chart is confusing: there are steps and elements and colors. Page 16, Element 2: here and elsewhere, lists would be made easier to read Para 2 – again, don't see corrections administrators being involved in population health programs
Apr 15 2014	Julie Trocchio	CHA	General Comments	Page 17: top line: by suggesting that the neutral convener should serve as trusted broker, you are suggesting that the local public health department or a leader of one of the organizations at the table could not take on this role. We disagree. Sometimes they could serve well in this role. Last dot point: How would a community collaboration work with or get information from the National Association of Medicaid Directors? Page 19: jails again
Apr 15 2014	Julie Trocchio	CHA	General Comments	Hello, Elizabeth. Here are our comments. Several of us at CHA have reviewed the document. We find it helpful, but have some specific and general recommendations. Please let me know if you want to discuss further. Page 3 • Para 3 - 5th word: replace "health" with "medical" • Para 4 and elsewhere: we do not think jails and criminal justice system belongs: law enforcement, yes, but do not see how jails would be part of a community health improvement program, unless it was a specific reentry program. • End of first dot point, add: "In addition to serving individual patients, many hospitals and other health care providers have a history, tradition, and mission of responding to health care needs of the broad community and vulnerable populations."
Apr 11 2014	Brian Donohue		General Comments	Elizabeth, Allen and Ahmed hello! I'd like to suggest an addition to "plain language guidance about how communities can work effectively with public health and clinical care systems....". In brief, please don't overlook public universities. I am sure you are thoroughly aware of the research function of public universities, but I am not talking about "reserach" at all. Public Universities and colleges also have a huge untapped reservoir of non-reserach assets and post-reserach" assets (labs, equipment, software, curriculum, applied reserach intellectual property and most importantly "human assets" (the knowledge and experience of people dealing with problems) which can be applied to addressing community, regional and world health problems through revenue-generating "public service contracts". The public university actually becomes a "social entrepreneur". I led the Business Contracts Office at UC Berkeley for 15 years and speak from direct experience but have no standing to speak for UCB at this time, but as a friend, I can share that a wonderful example of what I am talking about is Health Research for Action directed by Linda Neuhauser Ph.D. who is known to Ahmed. http://www.healthresearchforaction.org/ FYI - The "public service contracts" that I signed at UCB brought in $1 billion dollars over 15 years so it is a win-win-win. Mei Lin - could you forward this email to Ahmed as I do not have his email address. Please let me know if you interested in any more information. Thank you and respectfully, Brian Donohue

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Apr 15 2014	Darlene T. Huss		General Comments	Ms Elizabeth Carey: I would like to see the Healthy Minnesota Partnership Action Guide begin to encourage the residents of Minnesota, especially the metro area to move away from burning wood. I would like to see them encourage healthier forms of activity. There has been an incredilble increase in burning in Minneapolis in both winter and summer. MDH should be encouraging changing out fireplaces from wood burning to gas. Backyard burning should be banned altogether and I'd like to see the Healthy Minnesota Partnership take on educating the public on how harmful burning is on so many levels. I would also like to see them put pressure on the city to encourage them to work towards a total ban on backyard burning. There is nothing recreational about it. I've seen countless fires on Sunday morning left to burn all night unattended. Wood smoke is 12 times more carcinogenic than cigarette smoke. Plus there is no safe threshold for PM 2.5 particulates. I went for a 2.5 mile jog on Sunday morning--2 days ago-- down to the Mississippi about 11am and came accross 4 fires in NE Minneapolis. 11am on Sunday! Coming out of my house at 6:30pm Sunday I smelled smoke and leaving Church at 7:30pm I smelled smoke again. Around my neighborhood you see more and more chimneas and burners and more wood stockpiled for the backyard fire. Back in the 70s we got rid of the burn barrels when Nixon signed the Clean Air Act. We had cleaner air up until about 12 years ago and then suddenly there has been this proliferation of burning. I'm sure you know all about the harm that these particulates cause from immediate immune system responses to a correlation with heart attacks and strokes. I'm sure this burning contributes to the asthma rate in the metro being 2X that of outstate Minnesota. PM 2.5 particulates can stay airborn for weeks and are not stopped by windows--and it's especially bad in a neighborhood with 100 year old houses and 100 year old windows. Burning wood is bad for global climate change through putting soot into the atmosphere directly. But also through forcing people to close their windows in the summer and put on the air conditioner when the air quality is so bad, using more energy instead of being able to air the house naturally in the evening through open windows. I often smell smoke IN my house from backyard fires.
Apr 15 2014	Julie Trocchio	CHA	General Comments	Page 20 last para: We thought this section was how to set up and plan a prioritization process: this sounds like priorities among health needs take place in Element 3, before assessment. Don't think it is realistic. The order might need changing
Apr 15 2014	Julie Trocchio	CHA	General Comments	Page 23: para 3 Description of ACA hospital requirements is much too detailed. All the community coalition needs to know is that they much do CHNAs and involve public health and community engagement. Last para – Hospital are required to report their community health improvement and community building activities. Nothing requires them to provide such activities. The line: "Community building efforts must have a direct connection to promoting the health of the population served by the hospital including reducing disparities…" is not accurate. Maybe "should or "may" but there is no requirement. Page 24. First para, last line: This idea of shifting funds from financial assistance to community health improvement , put forward as a recommendation by the GW team, is not realistic. Hospital cannot shift 20% of their financial assistance and Medicaid cost to community health improvement without cutting off aid to very poor people who need medical care. This seems to be presented as a fact, but I think it is only a suggestion and does not belong in this paper, it suggests community groups can get a big pot of money from hospitals by asking them to do this, which is not possible.
Apr 16 2014	Vickie Boothe, MPH	Office of Public Health Scientific Services Centers for Disease Control and Prevention	General Comments	Dear NQF Subcommittee Members, Overall, I think this is a fantastic resource for fostering collaboration especially between public health and health care in the area of improving health across a population. Clearly much research and effort has gone into this well written draft. I only have a few comments and several resources you may also want to consider. 1. Page 9 "Health Disparities -- Differences in health status or health outcomes within a population." I would just bring to your attention that this is different than how HP2020 defines Health Disparities. Their definition is "A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage." The HP2020 definition is explained in detail in Braveman, P. A., Kumanyika, S., Fielding, J., et al. (2011). Health disparities and health equity: The issue is justice. AJPH, 101(S1), S149.
Apr 15 2014	Julie Trocchio	CHA	General Comments	2. Most helpful elements are (3) planning and priority setting, (4) Community health needs assessment, (5) health improvement activities and (6) selection of measures

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Apr 11 2014	Kristin Erickson, MS, PHN, RN	PartnerSHIP 4 Health	General Comments	In my initial brief review of the Improving Population Health by Working with Communities -- Action Guide 1.0 – DRAFT I noted something that might need to be addressed: p. 31 Table Two Measures/Indicators Live versus Life? Overall the guide content appears to be very well organized and comprehensive.
Apr 16 2014	Vickie Boothe, MPH	Office of Public Health Scientific Services Centers for Disease Control and Prevention	General Comments	6. Page 24, You may also want to consider the CDC/OSTLTS Web-based Resource Portal for Community Health Assessment & Health Improvement Planning located at http://www.cdc.gov/stltpublichealth/cha/index.html 7. “Element 6: Selection and Use of Measures and Performance Targets” You may also find the attached monograph, “Community Assessment for Population Health Improvement, Resource of Frequently Recommended Health Outcomes and Determinants”, useful. This resource resulted from a systematic review of seminal guidance documents that identified health outcomes and determinants that should be examined as part of community health assessment and improvement. It identifies the 42 most frequently recommended metrics and links to sources of valid and reliable community level dat
Apr 16 2014	Suzanne Duda	Healthways, Inc.	General Comments	Comment #2: Appendix C of the Guide lists data sources that may be useful to communities working to improve the well-being. We respectfully request inclusion of the Gallup-Healthways Well-Being Index and recommend referring to it as follows: Gallup-Healthways Well-Being Index. The Gallup-Healthways Well-Being Index is a measure derived from an empiric database of real-time changes in factors that drive well-being. The database captures perceptions on topics such as physical and emotional health, healthy behaviors, work environment, social and community factors, financial security, and access to necessities such as food, shelter and healthcare. Gallup conducts 500 telephone interviews a day with Americans to gather their perceptions of well-being, for a resulting sample that represents an estimated 95 percent of all U.S. households. http://www.healthways.com/solution/default.aspx?id=1125 Thank you for the opportunity to submit these comments. We would be pleased to answer any questions, and to re-submit them in the online system as soon as any technical difficulties are resolved. Sincerely, Suzanne Duda

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Apr 15 2014	Florence Reinisch, MPH	Healthy Communities Institute	General Comments	Requested Edits from Healthy Communities Institute 1) p. 24 [Note: a number of communities have similar websites, based on the model developed by the Healthy Communities Initiative, which support continuous learning. Other examples include www.healthysonoma.org and www.healthymarin.org] Replace with: [Note: over 100 communities have similar websites, based on the technology developed by the Healthy Communities Institute, which support continuous health improvement, evaluation, and learning. Other examples include www.healthysonoma.org and www.sfhip.org] 2) p.50 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/ replace with : Healthy Communities Institute (HCI) The Healthy Communities Institute provides customizable, web-based information systems to visualize the best-available local data through indicator dashboards and GIS maps. Supporting tools include Indicator Trackers for evaluation, a database of more than 2000 best practices, and collaboration tools to support ongoing collective work.
Apr 15 2014	Gina Boudreau	White Earth Nation	General Comments	Diane, The link you provided on page 34 for the tobacco program goes to Home Health Program. The tobacco program is under the health link go to Health Education and tobacco free communities to get our information on the coalition. Was this your intention for the White Earth Nation link provided? Also the contact information for Health Education is myself, Gina Boudreau ginamb@whiteearth.com and Health Education Program Manager LaRaye Anderson larayea@whiteearth.com Thanks Gina Boudreau White Earth Nation Tobacco Prevention Specialist 218-983-3286 Ext 1357

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Apr 16 2014	Suzanne Duda	Healthways, Inc.	General Comments	As we discussed I have had difficulty registering on the NQF system to submit comments on the Draft Community Action Guide. I appreciate your offer to forward these comments as appropriate, and I would be happy to enter them into the system as soon as the technical difficulties are resolved. We appreciate the opportunity to comment on the Guide and offer the following two comments: Comment #1: On page 28, in the section on Element 5, a Healthways program called Blue Zones Project is described. We propose deleting the existing description and replacing it with following: Blue Zones Project: Blue Zones Project is a community well-being improvement initiative designed to make healthy choices easier through permanent changes to environment, policy and social networks. The guiding principles are based on international research that identified nine healthy living principles in communities whose populations have achieved a high level of well-being and longevity. The project provides a framework for engaging public agencies, local business communities, schools and a wide range of civic organizations in setting priorities and taking concrete actions to achieve a common goal of improving the well-being of the community. www.bluezonesproject.com
Apr 7 2014	Mary Kushion	Mary Kushion Consulting, LLC	General Comments	12. Appendices B, C, and D appear to still be under consideration by the committee. I appreciate having them available at the end of the Guide and although I didn't check, it appears as all of the resources and tools provided in the Guide have been aggregated into a central location for quick reference. In the Resources and Tools section, I recommend organizing them by national, state and local examples. I also recommend adding which state the local examples come from – Muskegon County, MI is defined, but Camden is not and it would be helpful to the user if they knew the state. Again, thanks for the opportunity to provide comment. I look forward to seeing the Guide when it becomes available.
Apr 15 2014	Julie Trocchio	CHA	General Comments	1. There still seems to be too much narrative. The document would benefit from editing out non-essential information and the use of dot points and side bars. Guide would be more useful with real life examples. Examples that are given are really places to go for more information, not examples of how it is done.
Apr 16 2014	Stephanie Tucker, MD	University of Minnesota - Minneapolis School of Public Health	General Comments	Hello, My name is Stephanie Tucker and I am a Community Pediatrician in MN - dedicated to collaborative work in support of youth their families, communities and populations in health. I have special interests in prevention, collaboration, and innovations in care and population health. Thank you for all involved in developing the Draft. Although the draft includes many good suggestions - there is a critical void. In your draft - there is currently no emphasis on the absolutely essential need- to keep our first prioritization and focus always - on the health and unmet needs of the Child, the Individual, and the Population. I implore you to please consider adding this missing piece to the draft. Without emphasis of patient centered priorities first - unintended consequences can have devastating impact on the health of individuals and populations. In addition, please consider extending your deadline. We had only 1 day to review the draft - and many others who were unaware of the opportunity to comment - would like to add their input as well. With Urgency.... Thank you, -Stephanie

Date of Comment	Comment Submitter Name	Comment Submitter Organization	Question	Comment
Apr 15 2014 3:38PM	Christine Pozar	Highmark	What types of examples might still be needed to help illustrate topics that are unclear or particularly challenging?	Lists of barriers on the specific elements that were identified through implementation and potential solutions for improving on those issues More specific success stories and contacts Funding opportunities ROI - both financial and intrinsic value - for buy-in and sustainability
Apr 7 2014 2:32PM	Sarah Bergman	Allina Health	What types of examples might still be needed to help illustrate topics that are unclear or particularly challenging?	I thought Element 2, the leadership section, had some examples that were not entirely clear. For example, the link to the YMCA program didn't directly go to information related to Element 2. It took a couple of clicks to get to the section referenced.
Apr 15 2014 8:45PM	Erik Halaas	YMCA of San Francisco	What types of examples might still be needed to help illustrate topics that are unclear or particularly challenging?	I haven't had time to review all in detail so my insight is limited. I would agree with several of the comments above (reference to the importance of policy, examples of barriers and solutions, etc.). I think the concept of having this be a live document or web-based tool would strengthen the examples/additional resources section. This would allow those managing the content in the action guide to provide timely and relevant examples over time. Moreover, the lack of permanence could support some of the challenges associated with linking out to ever-changing resources (e.g. the comment above referencing a link that doesn't quite get to the desired page/website).
Apr 16 2014 11:58AM	Shawn Terrell	Administration for Commuity Living	What types of examples might still be needed to help illustrate topics that are unclear or particularly challenging?	Adding specific examples of how the elements are in use in home and community based services settings serving people with disabilities across the lifespan would enhance the potential of the guide being usefull for these populations and subpopulations.
Apr 16 2014 2:56PM	Julia Elligers	NACCHO	What types of examples might still be needed to help illustrate topics that are unclear or particularly challenging?	Examples related to health equity, social determinants, community engagement, interpersonal challenges.
Apr 16 2014 3:27PM	Alan Parver	Healthcare Nutrition Council	What types of examples might still be needed to help illustrate topics that are unclear or particularly challenging?	The Healthcare Nutrition Council encourages NQF to include examples that focus on identifying, preventing and treating disease-related malnutrition in a timely manner. Malnutrition negatively impacts population health since malnourished patients are at risk of adverse outcomes: Morbidity, Complications and Mortality: Malnourished patients are more likely to experience complications such as pneumonia, pressure ulcers, nosocomial infections, and death. Malnutrition is a risk factor for other severe clinical events, such as falls and worse outcomes after surgery or trauma. Length of Stay: Malnourished patients, and patients at risk for malnutrition, have significantly longer hospitalizations than well-nourished patients and patients not at risk for malnutrition. Readmission, Institutionalization and Ongoing Services: Malnutrition is a common reason for patients to be readmitted to hospitals. Hospitalized patients at risk of malnutrition are more likely to be discharged to another facility or require ongoing healthcare services after being discharged from the hospital than patients who are not at risk . Healthcare Costs: Malnutrition increases the cost of care. A recently retrospective health economic study found that providing oral nutritional supplements to Medicare patients was associated with a 16% reduction in length of stay and a 15.8% cost savings. Costs related to Increased Morbidity and Complications: High-risk malnourished patients are more likely to develop pressure ulcers than well-nourished patients. One study cited the average cost for hospital treatment of a stage IV pressure ulcer acquired in the hospital (including the treatment of associated medical complications) to be $129,248. The average cost of hospital treatment of a stage IV pressure ulcer acquired in the community (including the treatment of associated medical complications) was $124,327. Costs related to Hospitalizations: Hospitalized malnourished patients, patients at risk for malnutrition and patients who experience declines in their nutritional status while hospitalized have higher health care costs than well-nourished patients, patients not at risk for malnutrition, and patients who remain properly nourished during their hospitalizations, respectively.

Date of Comment	Comment Submitter Name	Comment Submitter Organization	Question	Comment
Apr 15 2014 4:56PM	Marice Ashe	ChangeLab Solutions	What types of examples might still be needed to help illustrate topics that are unclear or particularly challenging?	Examples of how public policy changes can create and sustain the environmental conditions in which people can be healthy would strengthen this document. For example, a call-out box could be added linking the root causes of disease or the social determinants of health to specific public policy strategies. For example: · Tobacco use prevention and cessation is promoted with smoke-free workplaces and public places. · Increases in physical activity in children is improved with policies that allow and promote Safe Routes to Schools, and those that open school recreation areas for after school community use. · Siting farmers markets is possible once land use planning policies allow for such activities. · Access to healthy food and beverage offerings is improved when school vending policies adhere to nutrition guidelines.
Apr 15 2014 2:35PM	Koryn Rubin	American Medical Association	What types of examples might still be needed to help illustrate topics that are unclear or particularly challenging?	Where possible, the guide might include vignettes (e.g., brief paragraph, a link to a video, etc.) on how a particular element was operationalized in context as part of the "How it can be done" section.
Apr 16 2014	Ruth Greenslade, MPP	Goodhue County Health and Human Services	What types of examples might still be needed to help illustrate topics that are unclear or particularly challenging?	Element 5 on agreed-upon priorities could be enhanced with some lists of decision-making processes (ways to vote, ways to rank competing priorities) in greater detail. The example given is "easy"—some root causes are easier to address than others, so the group agrees to work on that. Rarely is it so clear.
Apr 16 2014 5:18PM	Carmella Bocchino	America's Health Insurance Plans	What would make the Guide more useful, if anything?	We are supportive of this Action Guide as a path forward for improving population health. While this Guide contains useful elements important to improving population health, practical tools are needed to help communities translate this action guide into practice.
Apr 15 2014 4:59PM	Marice Ashe	ChangeLab Solutions	What would make the Guide more useful, if anything?	The Guide would be more useful with a stronger acknowledgement that changes in public policy are often needed both to create the environmental conditions in which all people can be healthy and to sustain the changes over time. While public policy is mentioned in Element 10 and while the concept of Health in All Policies is mentioned in several places, the overall message would be stronger if the power of public policy to truly impact health, disparities, cost, and sustainability was integrated throughout the document. Here are some examples of ways the document could be strengthened: E1:The guidance on self assessments would be more complete if they recommended a scan of existing state and local policies, as well as associated strengths, weaknesses, gaps, and opportunities to improve community health outcomes. E2:Local and/or state elected officials should be added to the list of stakeholders engaged in community health improvement efforts. These leaders have the power to direct and/or fund the work of much of the social services and regulatory apparatus in a community, and their vision, strategic thinking, and knowledge of a community are essential for success. It is important to foster these policy champions so they can lead the necessary changes in public policy required to improve health outcomes. It also could be strengthened by mentioning that community leadership development can include fostering coalitions that include organizations that have access to unrestricted funds. Those funds can be used for lobbying, if necessary, which is sometimes needed to achieve desired policy changes. E3:It is good to see "legal considerations" are listed in the Criteria to Identify Interventions for Health Needs. The Guide emphasizes the need to create regulatory and financial incentives that reward those who improve individual and population health. We support this guidance and add that such regulations presume participation in public policy change efforts to align the legal systems with desired health outcomes. We would also support adding a policy consideration to the Criteria to Identify Interventions; perhaps something like "Availability of policy levers to institutionalize the impact of the intervention." E4: The needs and asset assessments should be expanded to include an assessment of the state or local public policy environment. Many of the issues listed at the bottom of page 23, related to the social determinants of health (i.e., physical improvements and housing, economic development, environmental investments, etc.), presume engagement with a policy environment. Such an assessment would serve to create a policy action plan that identifies high priority policy needs, important coalition members, and

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Apr 15 2014 7:09PM	Dan Wohlfeiler	UCSF	What would make the Guide more useful, if anything?	Thank you for soliciting comments. Overall, the guide could be improved by drawing clear distinctions and providing examples from both healthcare settings as well as environmental and policy change. This is done in the third paragraph, but after that it is heavily weighted to h ealthcare. Use examples from both communicable and chronic diseases, with examples of common determinants including alcohol, education, and corrections. p. 4: Businesses have a relationship to health that goes beyond workplace Many have sought shared value by weaving health into their business models. There have also been numerous instances where business and public health have come into conflict and communities and public health have resorted to policies to mitigate the harms. The guide would be doing a service to help outline these different strategies. Include businesses (beyond “employers”) in the list of stakeholders on p. 16. p.4. The community building investment paragraph combines cost effectiveness through community building but uses a tobacco cessation program as an example. It would be better to use another community building example that does not rely on a service. Or cut this example out and just focus on the Camden, NJ, example. p.5: These are good examples but do not get at environmental or structural changes that do not require change at the individual level. 1 To what extent can organizations have a community impact and address social determinants, or will they be content to provide services to those affected by determinants? This gets mentioned in passing in Element 3 but I believe should be brought in earlier. 2. Is this organization the best suited to solve the problem at hand, or do others need to be brought in? On p. 33, “Audience specific Strategic Communication”, might be improved if very early on you included a clause that makes it
Apr 16 2014 5:10PM	Britta Orr	Local Public Health Association of Minnesota	What would make the Guide more useful, if anything?	Overall, it is a very useful and important guide. Discrete reference to the skills of local public health agencies and how they might be a leading and convening force in these efforts could be helpful. This is already a huge focus of their work. The opening was reasonably well organized, but didn't always flow logically. For example, there is a section that references "community building" activities (housing, etc), but then follows that up with an example highlighting the ROI of smoking cessation. The ROI itself (just over $2.00) is not that impressive of a number, but also cessation doesn't fit in the community building categories above. There could be more at the beginning about what is in this work for the business community. With the 10 elements, the first section after each seems to be a place we'd find the element in action: an example or illustration. The second section after seems to be general resources on how to do/perform that element. The difference between these categories isn't fully clear from their headings. For Element #6, a performance management framework/visual might be useful (terms like performance management, outcomes, and measures might also be considered as additions to the critical definitions on page 9).

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Apr 16 2014 2:53PM	Julia Elligers	NACCHO	What would make the Guide more useful, if anything?	The title of the guide suggests that community participation is valued; however, the action guide doesn't include information on how to engage the community. There is some language on engaging stakeholders, but even that is limited. Stakeholder engagement is not necessarily synonymous with community engagement and often focuses efforts on those in power and ignores the majority of the community. Overall, the language in the guide is top-down and suggests a paternatlistic approach, which has been shown to limit population health improvement. The decision to use population as a synonym for community ignores important aspects of community not captured in the definition of population. If there is an interest in social determinants approach, using the term population instead of community ignores the conditions that support or inhibit healthy living. Population is a scientific designation and typically not the focus on community mobilization efforts. Even though community might be difficult to define, it is a necessary step in population health improvement because the definition of community is what people rally around and are committed to improving. The referecnes to health equity and determinants of health are not substantively reflected in the different elements. The definition of health ignores the institutions and structures that cause inequity. The root cause analysis example does not go upstream enough. If the guide is intended to address inequity and social determinants, then it should be reflected in who is engaged, the types of data that should be collected, how data are analyzed, and which strategies should be implemented. Moreover, health equity or social determinants should be a standalone element. The guide does not address the interpersonal dynamics and challenges that end up being barriers to community health improvement. Competing interests, competition, history, turf, and politics need to be address in order to tackle the root causes of poor population health.
Apr 7 2014 2:31PM	Sarah Bergman	Allina Health	What would make the Guide more useful, if anything?	I would suggest cutting it down and making it shorter. The document says a couple of times that it is meant to be a short resource, but the length doesn't seem short. There are edits that could be made to the figures and tables to make them clearer. For example, labeling the chart axes (Figure 1, label Deaths Averted per 100,000) or working to make Figure 2 clearer (Leadership leading to leadership and communication leading to communication is a bit confusing, etc.). The reference to "Elements" doesn't seem as natural as calling it "Steps" although the naming may have been intentional.
Apr 15 2014 4:59PM	Marice Ashe	ChangeLab Solutions	What would make the Guide more useful, if anything?	(cont'd as per email PDF attachment) E5: The health improvement activities to address the root causes of disease mentioned on page 27 (unsafe neighborhoods, poor access to affordable and health food, etc.) presume an engagement with public policy. This should be explicitly discussed as an essential part of a community health improvement process. E6: Likewise, Element 6 should include mention that there are several policy performance targets available, such as the National Prevention Strategy, the CDC's new Prevention Status Reports, the Community Guide to Prevention Services, etc. E7: Communications strategies should include targeting elected officials, who generally must take action to improve state and local policies. This element should further include a statement that guides readers to effective means of engagement in allowable advocacy and to avoid impermissible lobbying. E8: A highly effective strategy to gauge progress on policy targets is a policy scorecard through which states and locoalities are rated on their inclusion of evidence-based policy strategies. The F as in Fat report by Trust for America's Health is just one example of this strategy. E9: If scalability is an important goal, public policy needs to be mentioned in this section. Indeed, policy is one of the most valuable tools available for expanding initiatives, as successful policies provide excellent foundations for additional improvement efforts and models for replication in other jurisdictions. E10: Long term sustainability is less likely to be achieved without public policies to institutionalize changes over time. Political advocacy may ofter be required to achieve the desired changes, so readers should be given tools to address how to properly engage in lobbying to avoid the misuse of philanthropic or federal funds. Both the Alliance for Justice and ChangeLab Solutions have relevant educational materials to guide community health leaders on lobby rules/

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Apr 16 2014 12:27PM	Shane Snowdon	Human Rights Campaign Foundation	What would make the Guide more useful, if anything?	As Director of Health & Aging at the Human Rights Campaign, the largest LGBT rights organization in the nation, I want to thank you for this vitally needed resource. We applaud and support your work to address health inequities and disparities in practical, community-based ways. Having reviewed the draft Guide, we believe that it could be more inclusive and helpful vis-à-vis LGBT inequities and disparities, which are many. As you know, a one-size-fits-all approach is not effective in changing population health generally, and LGBT people are certainly a population which needs and deserves specific attention, strategizing, and resources. We noted that LGBT people are mentioned at only two points in the Guide, on page 11 (as, in effect, an "other" population) and on page 9. On page 9, unfortunately, mention is made only of "sexual orientation"; while this variable, indeed, has important implications for population health work, "gender identity" should also be listed, as transgender people face marked health disparities and inequities. We also noted an absence of resources relating to LGBT needs, although "sexual health" is mentioned a number of times. (We would caution that LGBT people have health needs far beyond those related to sexual health.) To give just two examples of resources that should probably be mentioned, the Institute of Medicine produced a landmark report on LGBT health in 2011, and HRSA funded the Fenway Institute to develop LGBT population health strategies for and with community health centers; Fenway's resources are excellent and wide-ranging. We at the HRC Foundation would be happy to assist you in broadening LGBT inclusion in the Guide and incorporating additional LGBT-related resources.
Apr 16 2014	Ruth Greenslade, MPP	Goodhue County Health and Human Services	What would make the Guide more useful, if anything?	While "exact path forward …depends on situation" is a helpful clarification on page 7, the bullet points in the "How to Use this Guide" section could still be more specific. The last bullet point, which points to a specific tool on a specific page and explains specifically why it might be useful in your situation, is the best of the four. Listing page numbers and even hyperlinking right to the section or tool referenced would be a plus!
Apr 15 2014 8:48PM	Erik Halaas	YMCA of San Francisco	What would make the Guide more useful, if anything?	As the YMCA of San Francisco has recently begun to map out a strategic plan in accordance with a 2020 vision that focuses primarily on supporting the healthy development of youth in the Bay Area, the release of such an action guide is extremely helpful and timely. On behalf of the Y, I thank you for that. There are a few key areas for improvement. Action/Resource guides always present the challenge of overwhelming users with too many resources/too much information. I think that the comment above in reference to length is on point. An action guide should be simple, digestible, and leave little room for confusion as the folks most likely to be implementing such initiatives are likely to have a stretched capacity as is. With that in mind, I have a couple suggestions: I would limit each element to one to two pages in length. Carrying content beyond a page or two will lose the interest/focus of the reader and, ultimately, the impact/importance of each element; particularly if you end each section with a list of resources. I would carry this theme over by limiting the "How it can be done, with examples" section. It would be effective to maintain a similar format for each and limit to 1-3 key examples. I would leave the additional resource lists for the Appendices. While these are critical to appeal to a diverse array of readers, too much is too much. It is better to lose the reader after getting a comprehensive understanding of all 10 elements rather than losing them in the "additional resources" section after Element 1. An engaged reader/user will make light of a reference for further resources if it is there (e.g. See Appendix A for additional resources on "Self-Assessment of Readiness to Engage"). I like the direction that Appendix B references for the second phase in regards to providing a "recommended menu of measures" beyond just providing a list of example measures or similar resources. Based on the review committee, project staff, and additional reviewers, you're truly pulling from the experts. With this in mind, I think it would behoove NQF/HHS to taper the message of the action guide as much as possible to provide a more prescriptive roadmap for those on the ground. The meat of action guide should be directive while supplementary resources demonstrating the origin of the recommendations and various
Apr 16 2014 11:49AM	Shawn Terrell	Administration for Commuity Living	What would make the Guide more useful, if anything?	The definition of "health" (pg. 9) includes physical, mental, and social well-being. Home and Community Based Services (HCBS) for people with disabilities across the lifespan is concerned with the individual perceptions and goals related quality of life (QOL). Much of the QOL focus in the acute care field is that related to particular health conditions (e.g. QOL related to diabetes management). However, QOL within HCBS tends to be more closely related the social well-being aspect of the definition of

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Apr 16 2014 3:58PM	Alan Parver	Healthcare Nutrition Council	What would make the Guide more useful, if anything?	It is widely recognized that nutritional status plays an important role in health outcomes and healthcare costs. As NQF continues to develop and update the Guide, the Healthcare Nutrition Council (HNC) encourages NQF to urge organizations and individuals working to improve population health to focus on identifying, preventing and treating disease-related malnutrition in a timely manner. In the recent NQF 2014 Measure Application Partnership (MAP) report, malnutrition was identified as a measure gap and MAP members noted "they would like to see a more systematic assessment of ongoing progress towards gap-filling going forward." For this reason and the reasons set forth below, HNC also encourages NQF to consider endorsing a measure that promotes routine nutrition screening, assessment and appropriate nutrition intervention. Malnutrition is a significant, costly and often unrecognized problem. For over 30 years, large-scale studies have shown that as many as half of hospitalized patients and 35% to 85% of older long-term care residents are undernourished. Malnourished patients and patients at risk of malnutrition also live in the community. Significantly, patients' nutritional status often is not evaluated in a timely manner despite the common occurence and clinical relevance of malnutrition in older adults. Malnutrition is often associated with acute and chronic diseases and injury, such as cancer, stroke, and chronic obstructive pulmonary disease. These diseases and injuries may cause an individual to become malnourished by impairing the person's ability to ingest or absorb nutrients, causing increased energy needs or requiring a person to adhere to a restrictive diet. As a result, malnutrition has a significant negative effect on population health since malnourished patients are at risk of adverse outcomes including increased morbidity, complications and mortality, longer lengths of stay, increase likelihood for readmissions, institutionalizations and need for ongoing services and higher healthcare costs. Detecting malnutrition can be done easily and inexpensively by routinely screening patients in all settings for malnutrition and providing patients with timely, follow-up assessments, if needed. If further nutritional intervention is indicated, then providing patients with appropriate nutrition products and services in a timely manner can improve or maintain patients' nutritional status. As a result, population health will be improved since individuals will experience less morbidity and fewer complications, shorter hospital stays, and fewer hospitalizations and hospital readmissions. References available upon request.
Apr 16 2014 3:32PM	Marcia Wilson	Center for Health Care Quality	What would make the Guide more useful, if anything?	Thank you for the opportunity to comment on the first draft of the Community Action Guide. I commend the efforts of the multi-stakeholder committee in pulling together and synthesizing an enormous amount of information and resources. I believe that the ten steps identified in the Guide are appropriate and cover the primary activities to be undertaken by a multi-organization effort to improve the health of a population in a given community. I have three comments regarding the content of the Guide that reflects our experience in working with the sixteen Aligning Forces for Quality (AF4Q) communities. While the work to date in that program has largely focused on improving the quality of health care in the community, many of the components required for improving population health have been evident in the work of the AF4Q. These comments are not necessarily new thoughts, but I believe deserve particular emphasis in the context of work described by the Community Action Guide. First, it was unclear to me at what point during these ten steps is the lead organization identified. While this may be an implicit part of the process, I believe this is a critical step. This lead organization may not be responsible for carrying out all activities and may take more of a neutral convener role or one of a backbone organization (e.g., collective impact), but there ultimately needs to be one organization that is the glue that holds the program or initiative together. Second, when working with multiple organizations with varying agendas and perspectives, defining roles and responsibilities for each party is critical. In a multi-stakeholder environment, having clear lines of accountability is particularly important when no single organization is responsible for all components of a given program and initiative. While the document discusses identifying current community leadership and assessing current activities, undertaking a new program or initiative will require reexamining and possibly altering existing roles and responsibilities. Third, related to defining roles and responsibilities is identifying the type and scope of commitment needed from each engaged partner. In other words, how will the partner organization support the program or initiative? A commitment might mean any number of resources, e.g., financial, staff time, in-kind support, communications. Everyone engaged in the effort should be clear about how each organization will support a program or initiative.

Date of Comment	Comment Submitter Name	Comment Submitter Organization	Question	Comment
Apr 16 2014 4:46PM	Sanne Magnan	Institute for Clinical Systems Improvement	What would make the Guide more useful, if anything?	Thank you for the excellent Community Guide. I would offer only one comment for consideration. The "Organizational Planning and Priority Setting" process does not highlight the need to prioritize addressing per capita health care costs for population health, i.e., rising health care costs which are robbing the social determinants of health which in turn threatens population health. With the estimated inefficiency and waste in health care, there is an opportunity to not only extend coverage but also to further invest in population health. The guide does have a link to the IHI web site and the Triple Aim assessment tool which would encourage people to look at all aspects of the Triple Aim (care, health and costs). However, a specific mention of the role of decreasing per capita health care costs would be instructive. In the paper "Achieving Accountability for Health and Health Care" athttps://www.icsi.org/_asset/qj7tk6/Commentary---Magnan.pdf, there is a diagram (Community Reinvestment: A Reinforcing Loop) that illustrates how reinvesting savings from health careimprovements could be used to improve community health. Thank you for your consideration, and thank you for your work to improve community health. Sanne Magnan, MD, PhD Institute for Clinical Systems Improvement
Apr 15 2014 2:33PM	Koryn Rubin	American Medical Association	What would make the Guide more useful, if anything?	There should be a concise executive summary prior to the section on “Why focus on improving population health.” The individuals who will use this handbook will likely understand there is a need to improve population health but will need to know why and how this handbook will benefit them
Apr 14 2014 11:00AM	Donna Nichols	Directors of Health Promotion and Education	What would make the Guide more useful, if anything?	DHPE congratulates NQF for a great first start on this type of publication. It provides a comprehensive look at the process for population heath and serves as a good justification for what SHOULD be included.
Apr 16 2014 11:56AM	Shawn Terrell	Administration for Commuity Living	What would make the Guide more useful, if anything?	Add a specific mention of disabilities throughout the report wherever example lists of subpopulations are discussed (e.g. in the definition of “subpopulations” on pg. 9). This would significantly enhance the potential of the guide to be used in the home and community based services arena.
Apr 15 2014 3:34PM	Christine Pozar	Highmark	What would make the Guide more useful, if anything?	Examples of each elements successful implementations and contacts specific to that section. (success stories)
Apr 15 2014 4:56PM	Marice Ashe	ChangeLab Solutions	Which of the ten essential elements are most helpful, and why?	The guidance document makes a strong case for the importance of each of the ten elements. This is the correct perspective and there is no reason to select a “most important” element, as this is likely to change from community to community, depending on their needs and sophistication with this work. It is important to note, however, that there is no element specific to impact, disparities, or equity. There is mention of “priority setting” in Element 3; however, an element focused on reaching populations that have the least resources is critical to producing a guide that will help the communities that need it the most, especially if the guide will also include the public policy levers and considerations that make changes effective and lasting.
Apr 15 2014 8:48PM	Erik Halaas	YMCA of San Francisco	Which of the ten essential elements are most helpful, and why?	I’m with the others in stating that each of the 10 elements is integral to motivating positive change in population health. Moreover, as organizations set out to do such collaborative work it is necessary to constantly be reminded of each step along the way. I do appreciate the progressive nature of the elements from self-assessment to sustainability. Organizations often jump to Elements 5 and 6 without properly assessing personal readiness, community needs, and working collaboratively to identify best and shared strategies and measures to ensure solid outcomes/impacts. The same thing can be said about the back end (e.g. follow-up, joint reporting, etc.). Each element is important. Emphasizing the equal importance of the earlier steps (internal/external assessment) and later steps (follow-up, joint reporting, ongoing quality improvement, etc.) is very important.
Apr 16 2014 2:55PM	Julia Elligers	NACCHO	Which of the ten essential elements are most helpful, and why?	All elements had the same level of information, but it is unclear how local health departments and their community partners would use this guide to structure day-to-day work of population health improvement. While the National Association of County and City Health Officials (NACCHO) appreciates the mention of its Mobilizing for Action through Planning and Partnerships (MAPP) process under element 3, classifying it under that element only misrepresents what the process is about. In fact, MAPP provides guidance related to elements 1 through 8. I suggest looking at our newest edition of the MAPP Handbook. Further, most of our in-depth guidance is provided in face-to-face trainings and are not available online. If you'd like to learn more, please contact Julia Elligers at jjoh@naccho.org.
Apr 16 2014 5:14PM	Britta Orr	Local Public Health Association of Minnesota	Which of the ten essential elements are most helpful, and why?	Selection and use of measures and performance targets. This describes the issues and challenges of this topic very well, but is the one area with very limited capacity across many organizations. One suggestion to this section is recognizing the limited capacity in this area and to include a reference of having the right skill set at the table when identifying measures, etc (epidemiologists, researchers, program evaluators, etc) and what to do if you don't have access to these resources. Two other areas stand out as very helpful: 1) Self-assessment is a great foundational section; and 2) Communication is difficult and can be hard to understand strategically for those not formally trained in risk communication, etc.

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Apr 16 2014 11:53AM	Shawn Terrell	Administration for Commuity Living	Which of the ten essential elements are most helpful, and why?	The 10 essential elements are applicable to people with disabilites across the lifespan recieving home and community based serivces and supports. The addition of specific examples of the application of population health to the elements 1-10 would be greatly enhance this potential for the guide to be used in the home and community based services context. For instance Plan, Do, Study, Act cycles are used in many ACL funded Aging and Disability Resource Center grants. We would be happy to assist NQF in developing relevant case studies for inclusion to the Ten Key Elements.
Apr 15 2014 2:34PM	Koryn Rubin	American Medical Association	Which of the ten essential elements are most helpful, and why?	All ten elements are necessary to ensure success. An understanding of how to approach each area is fundamental in project planning. Individuals within organizations will likely have strengths in one or more of these areas, but can benefit from understanding the entire process. The one element that is least well thought out in improving population health is the selection and use of measures and performance targets.
Apr 7 2014 2:32PM	Sarah Bergman	Allina Health	Which of the ten essential elements are most helpful, and why?	I found 1, 3, and 6 to be the most helpful because the resources contain very practical information and were useful.
Apr 15 2014 3:35PM	Christine Pozar	Highmark	Which of the ten essential elements are most helpful, and why?	An Organizational Plannin and Priority-Setting Process. This is helpful for grass roots efforts.
Apr 16 2014	Ruth Greenslade, MPP	Goodhue County Health and Human Services	Which of the ten essential elements are most helpful, and why?	Element 3 explains Plan-Do-Study-Act, with a chart, and has links to MAPP and other initiatives that address organizational planning.
Apr 14 2014 11:02AM	Donna Nichols	Directors of Health Promotion and Education	Which of the ten essential elements are most helpful, and why?	All elements need to be enunciated. At this juncture it is important to include all essential components and not assume certain steps are intuitive.

NATIONAL QUALITY FORUM

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

Committee Roster

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NATIONAL QUALITY FORUM

Roster & Biographies

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NATIONAL QUALITY FORUM

Roster & Biographies

Committee Biographies

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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.

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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

NATIONAL QUALITY FORUM

Roster & Biographies

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.

NATIONAL QUALITY FORUM

Roster & Biographies

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

NATIONAL QUALITY FORUM

Roster & Biographies

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.

NATIONAL QUALITY FORUM

Roster & Biographies

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

NATIONAL QUALITY FORUM

Roster & Biographies

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.