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

NATIONAL QUALITY FORUM

Planning Meeting

Wednesday, October 23, 2013

1:00 pm – 3:00 pm ET

Telephone access:

Dial: 1-888-568-7852; Enter Confirmation Code: 84232137

Web Access:

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Table of Contents

Tab 1

Agenda

NATIONAL QUALITY FORUM

Agenda

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

Planning Meeting

Wednesday, October 23, 2013

1:00 – 3:00 pm ET

Instructions for Remote Participation:

Advisory Group Member/Speaker Instructions

1. Direct your web browser to: http://nqf.commpartners.com/se/NQFLogin/
2. Under "Enter a Meeting," type the meeting number **941078** and click "Enter."
3. In the "Display Name" field, type your first and last names and click "Enter Meeting."
4. Dial **1-888-568-7852** and use confirmation code **84232137**. Remember to turn off your computer speakers.

If you are going to share information for remote participation, please share the PUBLIC dial-in information below so the advisory group's private line is not disrupted.

Public Participant Instructions

1. Direct your web browser to: http://nqf.commpartners.com/se/NQFLogin/
2. Under "Enter a Meeting," type the meeting number **941078** and click "Enter."
3. In the "Display Name" field, type your first and last names and click "Enter Meeting."
4. Dial **1-888-799-5160** and use confirmation code **84232137**. Remember to turn off your computer speakers.

If you need technical assistance, you may press *0 to alert an operator or send an email to nqf@commpartners.com.

Meeting Objectives:

- Provide an overview of the project and desired outcomes;
- Receive guidance on the environmental scan of frameworks including selection criteria and approach to the analysis; and
- Provide feedback on initial list of frameworks for inclusion in the scan.

1:00 pm **Welcome and Introductions**

Karen Adams, Vice President, Strategic Partnerships, NQF

1:05 pm **Opening Remarks from our Sponsor**

Nancy Wilson, AHRQ, Government Task Lead

1:15 pm **Project Overview**

Elisa Munthali, Managing Director, Performance Measurement, NQF

- Scope and goals

1:30 pm **Discussion of Frameworks: Analytic Approach to the Environmental Scan**

- Criteria for selection
- List of Potential Frameworks for Inclusion in the Environmental Scan
    - State/community/local
    - Federal

Diane Stollenwerk, President, StollenWerks Inc.

- Proposed Analytic Approach
    - Convergence/Divergence

Allen Leavens, Senior Director, Strategic Partnerships, NQF

2:45 pm **Member and Public Comment**

2:55 pm **Next Steps**

Elisa Munthali

3:00 pm **Adjourn**

Tab 2

Web Meeting Presentation

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

Planning Meeting
October 23, 2013
1:00-3:00pm ET

1

Agenda at a Glance

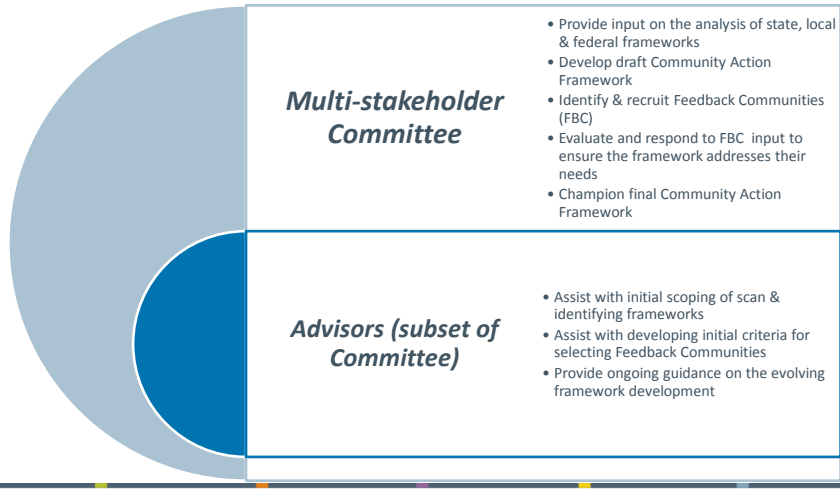
- Welcome & Introductions
- Project Overview
- Discussion of Frameworks: Analytic Approach to the Environmental Scan
- Member & Public Comment
- Next Steps

Welcome and Introductions

Core Advisors

Name	Organization
Catherine M. Baase, MD	Global Director of Health Services, Dow Chemical Company
Kaye Bender, PhD, RN, FAAN	President and CEO, Public Health Accreditation Board
Paul Jarris, MD, MBA	Executive Director, Association of State and Territorial Health Officials
Lloyd Michener, MD	Professor and Chair of the Department of Community and Family Medicine, Duke University Medical Center
David Nash, MD, MBA	Dean of the Jefferson School of Population Health
Bruce Siegel, MD, MPH	President and CEO, America's Essential Hospitals
David Stevens, MD	Associate Medical Director & Director of the Quality Center, National Association of Community Health Centers
Nancy Wilson, MD, MPH	Government Task Leader, AHRQ

Committee Roles



Lead Project Staff

Karen Adams, PhD, MT

Vice President, Strategic Partnerships

Elisa Munthali, MPH

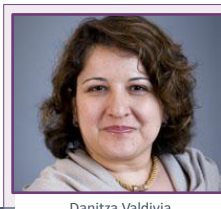
Managing Director, Performance Measurement

Allen Leavens, MD, MPH

Senior Director, Strategic Partnerships

Diane Stollenwerk, MPP

Consultant



Danitza Valdivia

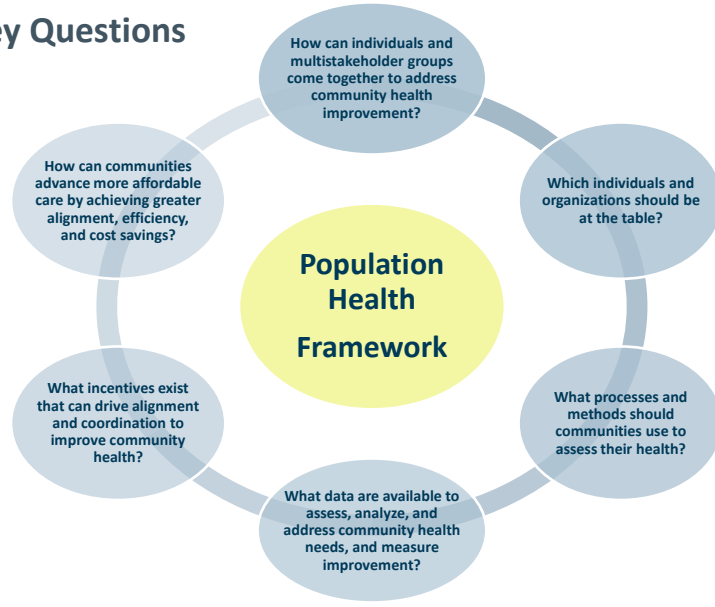
Administrative Manager, Strategic Partnerships

Project Overview

Audience & Purpose

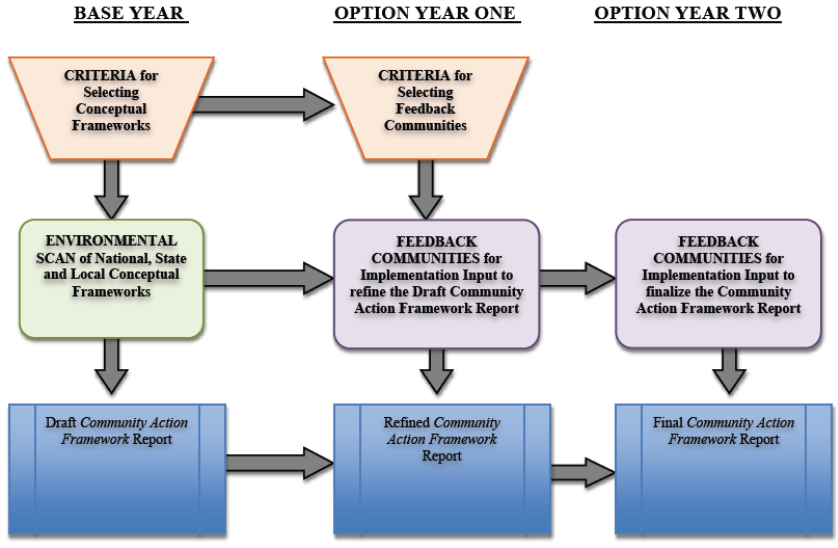
- **Communities, public health-** and **clinical care systems** need to work collaboratively to improve population health.
- **Shared definitions** and a **common conceptual framework** are needed to ensure better coordination and advance community partnerships.
- **Multistakeholder process** to develop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

Key Questions



NATIONAL QUALITY FORUM

Starting with the End in Mind: Connections across Project Deliverables



NATIC

Discussion of Frameworks:
Analytic Approach to the Environmental Scan

Selection Criteria:
Mix of Frameworks / Initiatives

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

- **Are any of the individual and 'mix' criteria higher priority?**

Selection Criteria: Individual Frameworks / Initiatives

- Involves *two or three*: a) clinical care, b) public health, c) other stakeholders
- Involves *most or all* of the following core elements:
  - Organizational **planning and priority-setting** process
  - Integrated **community health and needs assessment** process
  - Agreed-upon, **prioritized subset of health improvement activities** for which organizations direct resources and/or develop capacities
  - Responsibility for **leading a health improvement activity** in the region
  - **Selection of measures and performance targets** for population health outcomes, determinants of health, and health improvement activities
  - **Use of those indicators**, measured at the total population level, linked to the health improvement activities
  - **Reporting on progress** toward improving population health outcomes

Discussion Questions

- Framework / Initiative Selection Criteria
  - Should any element(s) in the individual criteria be treated as higher priority than others?
  - Should any element(s) in the 'mix' criteria be treated as higher priority than others?

Preliminary Candidate Frameworks

Federal/National Frameworks and Initiatives

- Department of Health & Human Services
  - Clinical-Community Relationships Measure Atlas; Healthy People 2020; HRSA Public Health Steering Committee Recommendations; National Quality Strategy; National Prevention Strategy
- Department of Defense
  - Operation Live Well & Healthy Base Initiative
- Other federal liaisons (e.g. Departments of Agriculture, Education, HUD, Justice, Labor, and Transportation; VA; EPA; OPM)
- Institute of Medicine reports
- National Business Group on Health - Employer Tool Kit
- National Quality Forum reports
- Other: RE-AIM, NHS, etc.

State and Regional or Community Frameworks or Initiatives

- Initiatives typically involve action, possibly using a framework
  - Tremendous array of state, regional or community activity
- Sources for state, regional, community frameworks or initiatives
  - References within frameworks or white papers, or mentioned by key stakeholders as outstanding examples
  - National programs that drive state action: IRS 501c3 Community Health Assessment; Public Health Accreditation; CMMI State Innovation Model Grants for Medicaid and CHIP Populations; National Commission on Correctional Health Care; etc.
  - National programs that drive local action: Foundation-funded population health projects; Aligning Forces for Quality; Chartered Value Exchanges; Quality Improvement Organizations; Beacon Community; YMCA; MATCH County Health Assessments; etc.

Discussion Questions

- Frameworks / Initiatives Under Consideration
  - Are there any high priority frameworks missing from this list?
  - Any advice regarding which to include or exclude?

Proposed Analytic Approach

Environmental Scan Analytic Approach: Framework and Initiatives

Potential dimensions for convergence and divergence

- **Focus Area** – Do the frameworks cover a broad definition of health?
- **Domains** – How well do the frameworks address key domains based on Recommendation #7 in the Jacobson and Teutsch report?
  - Organizational planning/priority setting
  - Assessing community health and needs
  - Prioritizing and leading health improvement activities
  - Choosing a prioritized set of appropriate measures/indicators
  - Providing joint reports on progress
- **Determinants of Health** – Are various determinants of health addressed within and across the frameworks?
- **Intermediate Outcomes** – e.g. Risk behaviors; physiologic measures; access, coverage, and use of preventive services; others?
- **Final Outcomes** – e.g. morbidity; mortality; birth rates; QOL; others?

Approach to Framework Analysis

Summary Matrix

Framework	Focus Area	Domains	Determinants of Health	Intermediate Outcomes	Final Outcomes
1					
2					!!!
3					
4			!!!	!!!	
5					
6					
7					
etc					

Environmental Scan Analytic Approach: Discussion Questions

1. Is there a conceptual framework involved, based on evidence?
2. To what degree does each framework or initiative meet the selection criteria? (fit, variation, gaps)
3. Key terms and related definitions
4. Types of stakeholders involved
5. Inclusion and use of tools, measures or data to help assess, plan for or improve behavioral, social and environmental determinants of health (plus impact, if known)

Environmental Scan Analytic Approach: Discussion Questions

6. Which of the seven core elements in the selection criteria are addressed most often; which are addressed least often?
7. Across frameworks, what are the:
    a) Areas of convergence
    b) Areas of divergence
    c) Standout individual components
8. What key issues should be addressed when defining what to include in the draft *Community Action Framework* report?

Public Comment

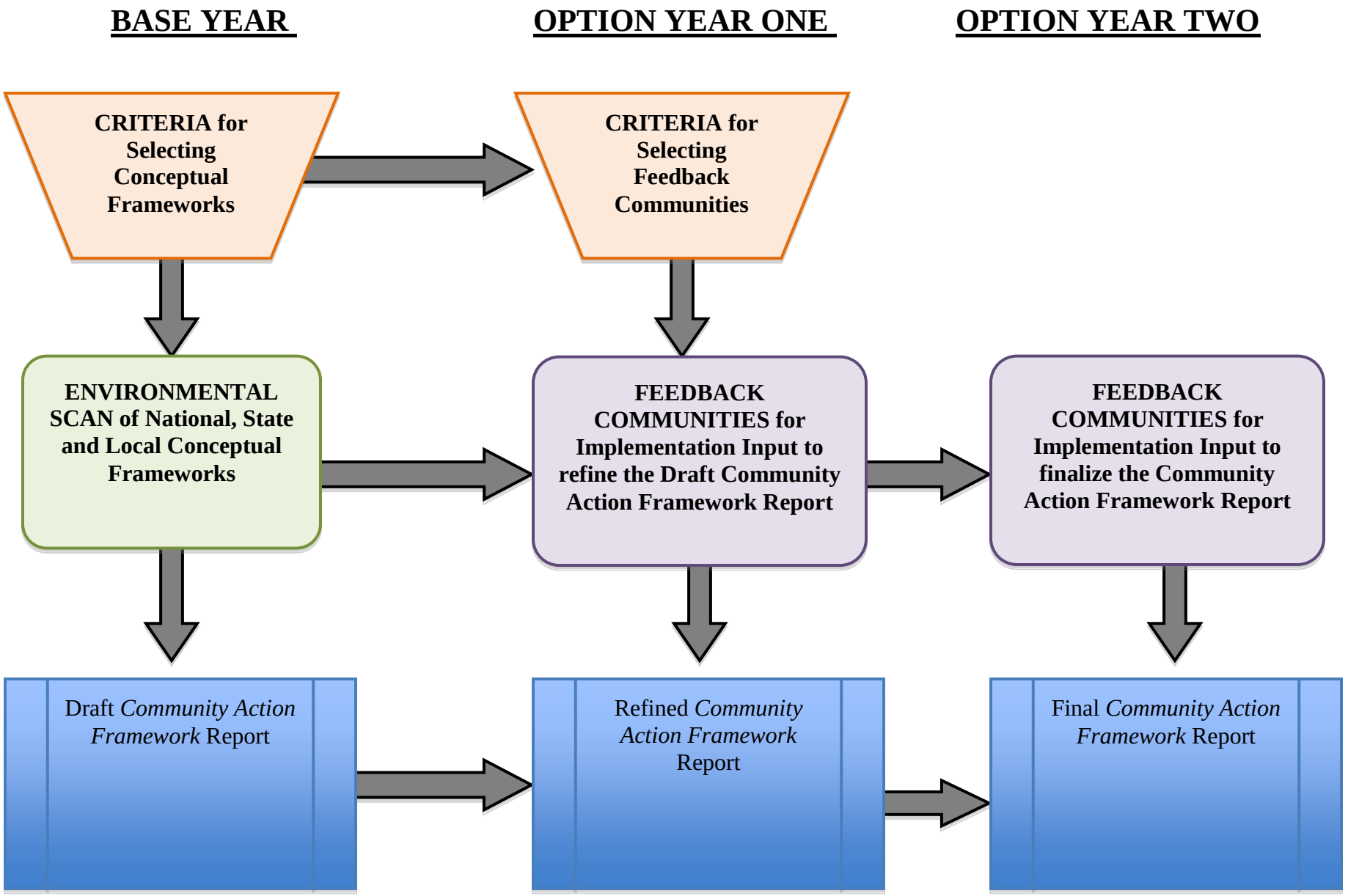
Next Steps

- Incorporate feedback on analytic approach and complete the environmental scan
- Perform comparative analysis of frameworks
- Draft written compilation of evidence-based frameworks, tools, measures, and data
- Prepare for January 9-10, 2014 in-person meeting of the full committee

THANK YOU!

Tab 3

Analytic Approach to the Environmental Scan


BASE YEAR
OPTION YEAR ONE
OPTION YEAR TWO
CRITERIA for Selecting Conceptual Frameworks
CRITERIA for Selecting Feedback Communities
ENVIRONMENTAL SCAN of National, State and Local Conceptual Frameworks
FEEDBACK COMMUNITIES for Implementation Input to refine the Draft Community Action Framework Report
FEEDBACK COMMUNITIES for Implementation Input to finalize the Community Action Framework Report
Draft *Community Action Framework* Report
Refined *Community Action Framework* Report
Final *Community Action Framework* Report

Mapping Connections Across Project Deliverables

BASE YEAR (project year one)

1. ***ENVIRONMENTAL SCAN*** of frameworks, tools, data and measures; creates foundation for *draft Community Action Framework report*
   - compiled from federal (max 20), state (max 10) and local (max 10) level, chosen based on selection criteria (Teutsch, diverse mix)
   - some of the state / local frameworks should be potential candidates for being selected as Feedback Communities (FBC - see Year 2)
   - compare and contrast relative merits of the frameworks collected, based on the selection criteria

2. ***DRAFT Community Action Framework report*** ("developed with the final deliverable in mind")
   - a set of defined measure domains, measures, and benchmarks that will inform the evolution of the National Quality Strategy and assist national efforts to drive progress on the Three Part Aim
   - a list of terms across the frameworks to consider for alignment
   - how the selected frameworks are used by communities to address behavioral, social, and environmental determinants of health
   - a list of essential stakeholders who should be engaged in community-based work in any systematic effort to improve population health
   - practical guidance that answers questions, such as:
     1. How should multi-stakeholder groups be brought together to address community health improvement?
     2. Which individuals and organizations should be at the table?
     3. What processes and methods should communities use to conduct assess their health?
     4. What data are available to conduct an assessment, analyze and address community health needs, and measure improvement?
     5. What incentives—e.g., measurement requirements for reporting or performance-based payment—exist that can drive alignment and coordination to improve community health?
     6. How can this process improve affordability by achieving greater alignment, efficiency, and cost savings?
   - references to high-impact national, state, and/or local programs that use measures in reporting and/or performance-based payment
   - drivers that affect the entities or stakeholders that are present in every community
   - opportunities to further align federal programs as well as public- and private-sector programs to reduce measurement burden
   - measures for possible NQF endorsement to fill gaps in population health and affordability
   - measure gaps and issues related to data for the production of actionable information

OPTION YEAR ONE (project year two)

1. **Selection of Feedback Communities**, based on written criteria and process to identify and select up to ten Feedback Communities (FBC)

2. ***REVISED Draft Community Action Framework report*** based on input from Feedback Communities

- document, analyze and factor in FBC perspective as implementers of the Draft Community Action Framework regarding the usability, barriers, refinements, possible solutions, gaps, etc.

OPTION YEAR TWO (project year three)

1. **FINAL *Community Action Framework and Implementation Guide*** report for communities to use to improve population health

- guidance on establishing cohesive and robust multi-stakeholder groups to improve population health, with opportunities for both public and private sector organizations
    - types to consider: public health, health care, departments of health, prevention, home and community-based services, purchasers, payers (health plans), consumers, social services, military, corrections, schools, EMS / EMT, federal agencies
- guidance on success factors and challenges (based on experience, insight, and recommendations of FBCs and multi-stakeholder group)
    - best practices to conduct a community health needs assessment (e.g., data, analytics, and prioritization)
    - where communities choose to start or focus and why
    - challenges from differences in culture, terminology, and barriers to progress
    - high impact incentives and disincentives
    - measure and data needs (available measure results and/or data sources most useful to informing efforts, other available information, information gaps)
    - examples in which improvements have taken place
- potential solutions (e.g., how to establish shared goals building on current efforts, connect and strengthen similar efforts, use common language or terminology)
- guidance on anticipating and quantifying economies and cost savings to be gained through collaborative approaches and by taking a ‘systems’ approach across a community

- a compendium of national and state programs and incentive, with insights on how these programs align or do not align with one another (insight for agencies and departments that to encourage better alignment and coordination)

NATIONAL QUALITY FORUM

Draft

Population Health Task 4 – Draft Criteria and Scope Recommendations

Purpose:

Define the scope to apply when identifying a list of initial frameworks / literature and evidence that should be cataloged and assessed as part of the base year goals of the 'Improve Population Health by Working with Communities' project.

Definitions:

The following clarification of the meaning of terms and related actions will help to ensure that expectations for the scope and related criteria are consistent across the entire project team.

1. "**Framework**" – a *conceptual* structure that shows important elements or actions and their relationship to each other in addressing population health improvement. For purposes of this project, frameworks will be identified from literature (peer-reviewed research or white papers) or will be ascertained by assessing the underlying structure implied by a State or community approach. Higher priority will be placed on evidence-based frameworks when available, recognizing that frameworks based on field implementation may not have undergone rigorous evaluation.
2. "**Tools**" – items such as surveys, communication materials, online calculators or other apps, etc. that can be used in the process to improve population health. Relevant tools identified in working with the federal government and with Feedback Communities will be included in the Community Action Framework/Template report.
3. "**Data sources**" – specific resources where organizations can access useful data for measuring or assessing social, environmental, behavioral and/or clinical elements that impact population health. Preference will be given to data sources that are widely available, however others may be included as good examples that might spur expanded data collection. Relevant data sources identified in working with the federal government and with Feedback Communities will be included in the Community Action Framework/Template report.
4. "**Measures**" – specific measures (including indicators, rates, numerical counts, etc.) that clinical health care systems, public health agencies and/or other stakeholders can use to assess key aspects of and/or contributors to the health of a population. Relevant measures identified in working with the federal government and with Feedback Communities will be included in the Community Action Framework/Template report.

   Note: for Items #1-4, *evidence-based* frameworks, tools, data and measures will be given priority. Understanding the variation in validation criteria and processes used even in third-party review of evidence, we will evaluate evidence on a case-by-case basis with Advisory Committee input.

5. "**Framework for Community Action**" – the content to be described in the draft paper in the base year, and refined in option years, which will include a recommended conceptual framework, in addition to tools, data sources and measures (see definitions above) to ensure that the final project deliverable is actionable. This deliverable will be called the "Community Action Framework" or the "Community Framework and Guide for Action."

6. "**Community**" – any geopolitical area, whether at the local, regional, state, or national level. The Community Action Framework is intended to capture and present recommendations that spur and support action at all levels of 'community.'
7. "**Total population health**" – health of all people within a given geopolitical area
8. "**Population health**" – health of all people in a distinct group or subpopulation within a given geopolitical area. Examples include all people with diabetes, elderly, children, and employees and dependents. While preference will be given for conceptual frameworks that address *total* population health improvement, the actionable elements of the Community Action Framework (tools, measures, data) will likely address specific subpopulation health needs.

Draft Criteria:

The following five parameters or criteria should be applied, in the following order, to determine which conceptual frameworks would be appropriate to include in the environmental scan. Parameters or criteria one and two will be used to identify the *individual* conceptual frameworks that are most appropriate for inclusion in the environmental scan. Parameters three, four and five will be used to ensure that the environmental scan will cover a high impact, comprehensive and diverse set of conceptual frameworks.

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

f. Use of the same prioritized indicators of intermediate and final health outcomes and determinants of health measured at the total population level, which are clearly linked to the health improvement activities noted under Item C above. [*at the subpopulation level.*]

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

Note: with input from the Advisory Committee, we will prioritize among the seven criteria above.

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

Preliminary Population Health Frameworks List

Framework (Initiative)	Source Description (Organization)	Location	Population Level	Focus Area	Comments
Southcentral Foundation's Nuka System of Care	Alaska's Southcentral Foundation	Alaska	Community / Regional, State	Health improvement activities	Southcentral Foundation's "Nuka System of Care" is a name given to the whole health care system created, managed, and owned by Alaska Native people to achieve physical, mental, emotional and spiritual wellness.
Primary Care and Public Health Integration Strategic Map: 2012-2014	ASTHO	Various	National; State	Multiple	The strategic map was created in response to the IOM Report titled: "Primary Care and Public Health: Exploring Integration to Improve Population Health." It is intended to guide ASTHO, its partners, and others in supporting integration of public health and primary care.
Camden Citywide Diabetes Collaborative	Camden Coalition of Healthcare Providers	New Jersey	Community / Regional	Diabetes	With the support from Merck Company Foundation's Alliance to Reduce Disparities in Diabetes and Bristol-Myers Squibb Foundation, the Coalition seeks to fundamentally change how providers, office staff, hospitals, and community agencies in Camden care for city residents with diabetes by building an accessible, high-quality, coordinated and data-driven health care delivery system with a strong primary care base.
Camden GPS Program	Camden Coalition of Healthcare Providers	New Jersey	Community / Regional	Violence intervention	Launched in 2010, the Camden GPS Program is a hospital-based violence intervention program that works with Camden youth and young adults who are treated for injuries related to assaults or intentional violence.
Pregnancy and Parenting Partners	Camden Coalition of Healthcare Providers	New Jersey	Community / Regional	Maternal and infant health	The Camden Coalition of Healthcare Providers and Cooper University Hospital are building a program to improve upon prenatal and infant care delivery in Camden, called Pregnancy and Parenting Partners (P3). The program combines group prenatal and well-child visits with a healthcare provider with education and support to address the reduced health and social functioning of socially disadvantaged parents and their children.
Healthy Community Alliance	Cattaragus County, NY DOH and Office of Rural Health	New York	Community / Regional	Rural health improvement	The Gowanda-based Healthy Community Alliance is a nonprofit rural health network established in 1996. The agency's service area encompasses 57 zipcodes and some 113,000 residents in portions of Cattaraugus, Chautauqua, Erie, and Wyoming counties. Strong partnerships have been established with groups and institutions all over Western New York. With a mission to improve quality of life in rural communities through broad-based, inclusive partnerships that support wellness and prevention, the Alliance focuses on programs and services for children and families that address chronic disease awareness, prevention, and management including physical activity and nutrition; youth mental health; and parent education.
DC Health Matters (see also Healthy Communities Institute)	Childrens' National Medical Center leading a coalition of hospitals	Washington DC	State, Community / Regional	Community / population health improvement	The DC Health Matters website is a community-driven, interactive web portal that provides actionable and timely local health information to DC communities and facilitates collaborations between and among community-based organizations (CBOs) and researchers.

Framework (Initiative)	Source Description (Organization)	Location	Population Level	Focus Area	Comments
Establishing a Coalition to Pursue Accountable Care in the Safety Net: A Case Study of the FQHC Urban Health Network	Commonwealth Fund Case Study on Population Health	Minnesota	Community / Regional, State	FQHC, community / population health	A coalition of 10 community health centers in the Minneapolis–St. Paul area recently formed one of the nation's first safety-net accountable care organizations—the Federally Qualified Health Center Urban Health Network, or FUHN, which seeks to provide higher-quality, lower-cost care to some 23,000 Medicaid beneficiaries.
Jails and Health Information Technology: a Framework for Creating Connectivity	Community Oriented Correctional Health Services	Various	Community / Regional, State	Corrections	Identifying an underlying connectivity framework of three macro systems that collect and communicate health care data about detainees: jail management systems, jail health systems, and community health systems. Ideally, all three systems would communicate seamlessly.
Operation Live Well	Department of Defense	Various	National	Multiple	The Department of Defense's health and wellness initiative. Also includes the Healthy Base Initiative.
Vermont Blueprint for Health	Department of Vermont Health Access	Vermont	State	Multiple	This report describes the cumulative growth trends of the number of participating and recognized primary care practices, the character and reach of the Community Health Teams, and the implementation of Support and Services at Home (SASH) for elderly and disabled Medicare beneficiaries.
HHS Action Plan to Reduce Racial and Ethnic Health Disparities	DHHS	Various	National	Disparities	Outlines goals and actions HHS will take to reduce health disparities among racial and ethnic minorities.
National Prevention Strategy American's Plan for Better Health and Wellness	DHHS	Various	National	Multiple	Through partnerships, the National Prevention Strategy will improve America's health by helping to create healthy and safe communities, expand clinical and community-based preventive services, empower people to make healthy choices, and eliminate health disparities.
Healthy People 2020	DHHS	Various	National, State, Community/Regional	Multiple	Healthy People is a set of goals and objectives with 10-year targets designed to guide national health promotion and disease prevention efforts to improve the health of all people in the United States.
National Strategy for Quality Improvement in Health Care	DHHS	Various	National	Multiple	Effort to create national aims and priorities to guide local, state, and national efforts to improve the quality of health care in the United States.
Clinical-Community Relationships Measures Atlas	DHHS - AHRQ	Various	National	Multiple	The Clinical-Community Relationships Measures (CCRM) Atlas is designed to provide users with a measurement framework and listing of existing measures for clinical-community relationships; intended to help facilitate research, quality improvement projects, and other interventions investigating clinical-community relationships that have been formed for the purposes of improving the delivery of clinical preventive services; and intended to be used by researchers studying clinical-community relationships as well as evaluators of these relationships.
Health Impact Pyramid	DHHS - CDC	Various	National	Multiple	A 5-tier pyramid describing the impact of different types of public health interventions and providing a framework to improve health.

Framework (Initiative)	Source Description (Organization)	Location	Population Level	Focus Area	Comments
The Guide to Community Preventive Services	DHHS - CDC (in part)	Various	National, State, Community / Regional	Varied	The Guide to Community Preventive Services is a free resource to help choose programs and policies to improve health and prevent disease in the community. Systematic reviews are used to answer these questions: Which program and policy interventions have been proven effective? Are there effective interventions that are right for my community? What might effective interventions cost; what is the likely return on investment?
State Innovation Models Initiative (SIM) - Medicaid and CHIP	DHHS - Center for Medicare & Medicaid Innovation (CMMI)	Six states have received SIM grants, several others have received planning grants	State	Medicaid population health improvement	The State Innovation Models Initiative is providing up to $300 million to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states. The projects will be broad based and focus on people enrolled in Medicare, Medicaid and the Children's Health Insurance Program (CHIP).
QIO / CMS: Care Transitions Theme	DHHS - Centers for Medicare & Medicaid Services (CMS)	Various	Community / Regional, State	QIO role in improving population health by reducing readmissions and overall admissions	From 2008 through 2011, CMS' Care Transitions Theme, a 14-community initiative through the Quality Improvement Organization (QIO) contract, significantly reduced both 30- day readmissions and overall admissions per 1,000 Medicare beneficiaries at a greater rate than a cohort of 50 comparison communities. In 2011, CMS expanded this community-based approach to reducing readmissions and improving care transitions to every state and territory through the current QIO initiative.
CMMI Measurement Framework	DHHS - CMS	Various	National	Multiple	Introduced in late 2011 as part of a cooperative agreement solicitation, this framework places the first two aims of the Triple Aim (Better Care and Better Health) in the context of total population health (community) outcomes.
HRSA Public Health Steering Committee Recommendations	DHHS - HRSA	Various	National	Multiple	HRSA's Public Health Steering Committee developed 11 specific recommendations grouped into five strategic categories believed to be essential drivers of a HRSA Public Health Agenda: • Achieving Health Equity; • Linking/Integrating Public Health and Primary Care; • Strengthening Research & Evaluation, Assuring Availability of Data and Supporting Health Information Exchange (HIE); • Assuring a strong Public Health and Primary Care Workforce; and • Increasing Collaboration and Alignment of Programs Within HRSA and Among Our Partners.
Leading Change: A Plan for SAMHSA's Roles and Actions2011–2014	DHHS - SAMHSA	Various	National	Behavioral health	Details eight Strategic Initiatives that will provide a framework to support the vision and mission of the Substance Abuse and Mental Health Services Administration.

Framework (Initiative)	Source Description (Organization)	Location	Population Level	Focus Area	Comments
Improving the health of the community: Duke's experience with community engagement	Duke University Health System; City and County of Durham, North Carolina	North Carolina	Community / Regional	Improving health through innovative behavioral, social, and medical knowledge, matched with community engagement	More than a decade ago, Duke and its community partners began collaborating on projects to meet specific, locally defined community health needs. In 2005, Duke and Durham jointly developed a set of Principles of Community Engagement reflecting the key elements of the partnership and crafted an educational infrastructure to train health professionals in the principles and practice of community engagement. And, most recently, Duke has worked to establish the Duke Translational Medicine Institute, funded in part by a National Institutes of Health Clinical Translational Science Award, to improve health through innovative behavioral, social, and medical knowledge, matched with community engagement and the information sciences.
Practical Playbook	Duke University Medical Center, the Centers for Disease Control and Prevention, and the de Beaumont Foundation	Unknown	Community / Regional, State	Community / population health improvement	The Practical Playbook is a free, content-rich resource for public health and primary care groups that wish to work together to improve population health. The web-based, interactive tool fosters mutual learning by guiding primary care and public health users through the stages of integrated population health improvement. The Playbook also references and provides external resources and information that can assist with integration efforts.
Blue Zones Project	Healthways	Various	National, State, Community / Regional	Healthy lifestyle habits	The 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. Tools are based on nine healthy lifestyle habits shared by the people living in the original Blue Zones® areas. Called the Power 9®, they help people live healthier and happier longer.
Population and Community Health: Data and Decision Support Information System	Healthy Communities Institute	Various (replicated in many communities)	National, State, Community / Regional	Community / population health improvement	Used by many local public health groups, the Healthy Communities Network (HCN) is a customizeable web-based information system designed to provide access to high-quality data and decision support. The HCN provides health indicator tracking, best practice sharing and community development in order to help improve the health and environmental sustainability of communities around the world.
Let's CHANGE (Commit to Healthy Activity and Nutrition Goals Every day)	Healthy Memphis Common Table	Memphis TN	State, Community / Regional	Cardiovascular health, obesity	Let's CHANGE (Commit to Healthy Activity and Nutrition Goals Every day) is a partnership with the Healthy Memphis Common Table and the Shelby County Health Department to fight childhood and family obesity by creating a culture of healthy living. Let's CHANGE includes over 37 organizations spanning a broad spectrum of businesses, community-based organizations, and government.
Project Healthy Grad	Healthy Muskegon County	West Michigan	Community / Regional	Education	West Michigan's Project Healthy Grad AF4Q PHP initiative aims to increase high school graduation rates, while ensuring all high school students are prepared for and have access to post-secondary education.

Framework (Initiative)	Source Description (Organization)	Location	Population Level	Focus Area	Comments
Hennepin Health	Hennepin County	Hennepin County, MN	State, Community / Regional	Comprehensive approach to patient health and wellness	Hennepin County provides health and human services to more than 200,000 residents via its cooperative network, which includes Hennepin County Medical Center, NorthPoint Health and Wellness Center, Metropolitan Health Plan, and the Human Services and Public Health Department. We plan to build upon this tradition of collaboration to create an integrated health care delivery network -- called Hennepin Health -- that blends medical, behavioral health and social services in a patient-centered care model.
Hospital Community Benefit Program (see IRS 501c3 rules)	Hilltop Institute	Various (applies to hospitals across the USA)	National, State, Community / Regional	Community / population health improvement	The Community Benefit State Law Profiles (Pro- files), launched in March 2013, are an open-access online resource for under- standing each state's community benefit framework, as defined by state law, regulation, and, occasionally, the policies and actions of state executive agencies. Each state's profile is framed in terms of the community benefit provisions of §9007 of the Affordable Care Act (ACA)2 and §501(r) of the Internal Revenue Code (IRC).
Chartered Value Exchanges (CVEs): Sources of Population-Based Measures and Data	Institute for Healthcare Improvement & The Commonwealth Fund	Various (24 CVEs nationwide)	Community / Regional, State	Multiple	Exploring the AHRQ Learning Network for Chartered Value Exchanges Population-Based Measures: Exactly What Are They, What's Available, and How Might They Be Used by CVEs? By David Radley, Ph.D.
Public Health Strategies to Improve Health	Institute of Medicine (IOM)	Various	National	Multiple	In 2009, the IOM formed a committee to consider three topics related to population health: data and measurement, law and policy, and funding. In this final report, the IOM assesses both the sources and adequacy of current government public health funding and identifies approaches to building a sustainable and sufficient public health presence going forward, while recognizing the importance of the other actors in the health system, including clinical care, governmental public health, and others.
Roundtable on Population Health Improvement (framework)	Institute of Medicine (IOM)	Various		Population health	The roundtable brings together individuals and organizations that represent different sectors in a dialogue about what is needed to improve population health. The Roundtable will engage roundtable members and outside experts, practitioners and stakeholders on key issues.
Toward Quality Measures for Population Health and the Leading Health Indicators	Institute of Medicine (IOM)	Various	National	Multiple	IOM report listing recommendations designed to inform and support the development, endorsement, promotion, and use of a unified and coherent set of quality measures useful across a range of settings.
Primary Care and Public Health: Exploring Integration to Improve Population Health	Institute of Medicine (IOM)	Various	National	Multiple	IOM identifies a set of core principles derived from successful integration efforts – including a common goal of improving population health, as well as involving the community in defining and addressing its needs.
Engaging the Public in Critical Disaster Planning and Decision Making - Workshop Summary	Institute of Medicine (IOM)	Various	National	Multiple	This report introduces key principles of public engagement, provides practical guidance on how to plan and implement a public engagement activity, and presents tools to facilitate planning.
For the Public's Health: The Role of Measurement in Action and Accountability	Institute of Medicine (IOM)	Various	National	Multiple	IOM review of current approaches for measuring the health of individuals and communities and suggests changes in the processes, tools, and approaches used to gather information about health outcomes and their determinants.

Framework (Initiative)	Source Description (Organization)	Location	Population Level	Focus Area	Comments
Non-Profit 501c3 Hospital Community Benefit Requirements	IRS	Various (applies to hospitals across the USA)	National, State, Community / Regional	Community / population health improvement	In 2010, ACA §9007 instituted additional federal requirements that nonprofit hospitals must meet to establish or maintain eligibility for federal tax exemption. This includes conducting a community health assessment and creating a community heatlh improvement plan with metrics.
KanCare	Kansas Department of Health and Environment	Kansas	State	Integrated care to improve health across the Medicaid population	KanCare is the Kansas Medicai program. Launched in January, 2013, KanCare is delivering whole-person, integrated care to more than 360,000 people across the state. Kansas contracted with three health plans, or managed care organizations (MCOs), to coordinate health care for nearly all Medicaid beneficiaries.
Community Health Initiatives	KP	Various	Community/Regional	Multiple	Kaiser Permanente's goal for its place-based Community Health Initiatives is to improve the health of every resident living in the 40+ participating communities. These "population-level" improvements focus on achieving outcomes such as increased physical activity, healthier diets, reductions in obesity, and improvements in obesity-related health issues such as high blood pressure and diabetes.
Results-Based Accountability Framework (modified)	Los Angeles County Department of Public Health	Various	National, State, Community/Regional	Multiple	Delineates two different sets of measures, one representing total population outcomes and another representing health improvement activities.
Expand Tobacco Policy Outreach and Development to an American Indian Tribal Community	Minnesota Community Measurement	Minnesota	Community / Regional, State	Tribal health; tobacco cessation	This initiative, managed by MN Community Measurement and spearheaded by the Great Plains Tribal Chairmen's Health Board (GPTCHB), will expand tobacco policy outreach and development to an American Indian Tribal community in Minnesota. GPTCHB will lead the development of an inventory of current tribal tobacco control policies, design training modules and technical assistance to tribal health departments to become certified in tribal tobacco control, implement the tribal tobacco policy toolkit, and conduct both the American Indian Adult Tobacco Survey and the Youth Tobacco Survey for Minnesota's White Earth Nation.
Minnesota Heart Disease and Stroke Prevention Plan	Minnesota Department of Health	MN	State, Community / Regional	Improving cardiovascular health and preventing strokes	The Minnesota Heart Disease and Stroke Prevention Plan 2011-2020 provides a road map and call to action for individuals, communities and organizations to collaborate and implement strategies that will enable Minnesota to successfully prevent, treat and manage heart disease and stroke.
Beacon Community Program	National Coordinator for Health IT (ONC) - HHS	Various	State, Community / Regional	Health care data interchange, data exchange with other service providers in some regions	The Beacon Community Cooperative Agreement Program demonstrates how health IT investments and Meaningful Use of electronic health records (EHR) advance the vision of patient-centered care, while achieving the three-part aim of better health, better care at lower cost. The HHS Office of the National Coordinator for Health IT (ONC) is providing $250 million over three years to 17 selected communities throughout the United States that have already made inroads in the development of secure, private, and accurate systems of EHR adoption and health information exchange.

Framework (Initiative)	Source Description (Organization)	Location	Population Level	Focus Area	Comments
Improving Health: An Employer Toolkit	NBGH	Various	National	Multiple	The Institute of Medicine (IOM) of the National Academies Press completed a landmark study assessing how integrated health programs lessen the impact of illness on employees and employers. The IOM and the National Academies Press allowed NBGH to extract key findings of the study to provide this "Improving Health: An Employer Tool Kit."
The National Service Framework for Coronary Heart Disease	NHS	Various	National	Cardiovascular health	The National Service Framework (NSF) for CHD, published in March 2000, is a blueprint for action to reduce incidence of coronary heart disease and modernise the NHS by driving up standards and cutting variations in services. This report details the progress which has been made in implementing the CHD NSF in the four years since its publication.
Multiple Chronic Conditions Measurement Framework	NQF	Various	National	Multiple	This report establishes a measurement framework for individuals with multiple chronic conditions. The framework addresses the complex circumstances of these individuals, and is intended to serve as a guide for future measure development and NQF-endorsement decisions pertaining to measures that address this vulnerable population. In addition, the framework will help guide measure selection for public reporting and payment; suggest a roadmap for new care delivery models; and inform research.
Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care	NQF	Various	National	Multiple	This report presents the NQF-endorsed® measurement framework for assessing efficiency, and ultimately value, associated with the care over the course of an episode of illness and sets forth a vision to guide ongoing and future efforts.
"Health Care As if Health Mattered" Framework [drawn from JAMA article 2/7/08]	ONC	Various		EHRs as a key tool in population health improvement	Article explores ways to use EHRs so that health improvement is a clear focus and outcome
Regional Equity Atlas 2.0 and Action Agenda	Oregon Health Care Quality Corporation	Portland, OR	Community / Regional	Community / population health improvement	The Oregon Health Care Quality Corporation is partnering with the Coalition for a Livable Future (CLF) to develop the Regional Equity Atlas 2.0 and accompanying Action Agenda. This AF4Q MATCH initiative will lead multiple partners to map the intersection of chronic disease prevalence data and data on the social, economic, and physical determinants of health for the Portland metro region.
Healthy Start, Healthy Future for All	P2 Collaborative of Western NY	Western New York	Community / Regional	Obesity	This initiative is managed by the P2 Collaborative of Western New York (WNY) in collaboration with community partners to provide school-aged children, their families, and the entire community with activities that will establish a foundation for making healthy choices about fitness and nutrition at an early age to minimize the trend towards obesity and weight-related illnesses.
Family Wellness Warriors Initiative (FWWI)	Southcentral Foundation	Alaska	Community / Regional, State	Domestic violence, abuse and neglect prevention	Family Wellness Warriors Initiative (FWWI) seeks to address the devastating problems of domestic violence, abuse, and neglect in the Alaska Native community. Its purpose is to equip organizations and individuals to effectively address the spiritual, emotional, mental, and physical effects of domestic violence, abuse, and neglect.

Framework (Initiative)	Source Description (Organization)	Location	Population Level	Focus Area	Comments
Baltimore Community Health Initiative	State of Maryland	Baltimore, MD	Community / Regional	Community / population health improvement	The Community Health Initiative is a collaborative effort to engage East Baltimore residents, community groups, city officials and Johns Hopkins in an intense process of planning and critical thinking about how best to develop and implement a community health assessment. This is the first phase a larger initiative, which aims to improve the health and well-being of residents of all ages who live in five zipcodes of East Baltimore through sustainable health collaborations and specific health interventions.
Optimal Healing Environments Framework	The Samueli Institute	Various		How the social, psychological, spiritual, physical and behavioral components of an organization can affect the inherent healing capacities of those within it	For the past decade, Samueli Institute has worked to uncover how healing occurs among individuals, communities and health care systems. As a result, Samueli Institute developed the Optimal Healing Environments framework to show how the social, psychological, spiritual, physical and behavioral components of an organization can affect the inherent healing capacities of those within it. The framework was developed for, and has been successful in, hospital and health care systems.
Green Strides	U.S. Department of Education	Various	National, State, Community/Regional	Multiple	Aims to facilitate the sharing of best practices and resources in the areas of facilities, health and environment, and the critical collaborations that ensure all of our nation's schools are healthier, safer, and more sustainable.
Moving Healthy: Linking FHWA Programs and Health	U.S. Department of Transportation Federal Highway Administration	Various	National, State	Safety	FHWA programs, funding sources, and tools that can support health-related issues in communities across the country.
Let's Move	U.S. Executive Branch with other federal and private partners	Various	National, State, Community/Regional	Obesity	Let's Move! is a comprehensive initiative, launched by the First Lady, dedicated to solving the problem of obesity within a generation.
Roadmaps to Health (County Health Rankings or MATCH)	University of Wisconsin Population Health Institute	Various	State, Community / Regional	Community / population health improvement	The County Health Rankings & Roadmaps program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps help communities create solutions that make it easier for people to be healthy in their own communities, focusing on specific factors that we know affect health, such as education and income. Having health insurance and quality health care are important to our health, but we need leadership and action beyond health care.
Reach Effectiveness Adoption Implementation Maintenance (RE-AIM)	Virginia Tech	Various	National	Multiple	Per the RE-AIM website: "The RE-AIM framework is designed to enhance the quality, speed, and public health impact of efforts to translate research into practice..."
YMCA of the USA's Healthier Communities Initiatives—Pioneering Healthier Communities	YMCA	Various: more than 160 across the USA	National, Community / Regional	Healthy lifestyle habits	Healthier Communities Initiatives are built on the concept that local communities can work together to give all community members healthy choices and support the pursuit of healthy lifestyles. More than 160 Ys are working in collaboration with community leaders to make changes in policies and the physical surroundings in those communities so that healthy living is within reach for individuals of all ages and backgrounds.

Tab 4

Advisory Group Roster & Biographies

NATIONAL QUALITY FORUM

Roster & Biographies

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

Advisory Group Roster

Population Health Framework Advisory Group		
Name	**Organization**	**Email**
Catherine M. Baase, MD	*Global Director of Health Services, Dow Chemical Company*	cbaase@dow.com cc: SMForbes@dow.com
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David Nash, MD, MBA	*Dean of the Jefferson School of Population Health*	david.nash@jefferson.edu cc: elizabeth.debonis@jefferson.edu
Bruce Siegel, MD, MPH	*President and CEO, America's Essential Hospitals (Former name: National Association of Public Hospitals and Health Systems)*	bsiegel@essentialhospitals.org cc: pchibambo@essentialhospitals.org
David Stevens, MD	*Associate Medical Director & Director of the Quality Center, National Association of Community Health Centers*	dstevens@nachc.com
Nancy Wilson, MD, MPH	*Government Task Leader, HHS/AHRQ*	Nancy.Wilson@ahrq.hhs.gov

Advisory Group Biographies

Catherine 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 U.S. 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.

Kaye Bender, PhD, RN, FAAN, is the President and CEO of the Public Health Accreditation Board, a position she has held part-time since January 2009 and 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 as past chair of the Public Health Leadership Society.

Paul E. Jarris, **MD, MBA,** is Executive Director of Association of State and Territorial Health Officials (ASTHO), a national nonprofit organization that represents public health agencies of the United States, the U.S. 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 IOM Board on Health Sciences Policy.

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 and the Association of Departments of Family Medicine, and the National Patient Safety Foundation Board of Governors. Dr. Michener is also co-chair of the NIH's Community Engagement Steering Committee and a member of the CDC Foundation Working Group on Public Health and Medical Education. Dr. Michener has focused on finding ways of making health care 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.

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 including American Journal of Medical Quality, Population Health Management, and Biotechnology Healthcare.

Bruce Siegel, MD, MPH, has an extensive background in health care 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.

David Stevens, MD, is Associate Medical Director and Director of the Quality Center at National Association of Community Health Centers. Dr. David Stevens, 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 in 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) and director of Clinical Management and Professional Management and chief medical officer of the Division of Community and Migrant Health.

Tab 5

Lead Staff Contacts

NATIONAL QUALITY FORUM

Lead Staff Contacts

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

NAME	TITLE	CONTACT INFORMATION	ROLE
Karen Adams	Vice President, National Priorities	kadams@qualityforum.org	Strategic guidance & HHS point person
Allen Leavens	Senior Director, Strategic Partnerships	aleavens@qualityforum.org	Research/ analytics for scan & evidence-based framework. Liaison to NQF-MAP.
Elisa Munthali	Managing Director, Performance Measurement	emunthali@qualityforum.org	Committee support & oversight. Liaison to NQF-CDP.
Diane Stollenwerk	President, StollenWerks Inc. Consultant with extensive community-based expertise.	diane@stollenwerks.com	Environmental scan analysis & evidence-based framework development.
Danitza Valdivia	Administrative Manager	dvaldivia@qualityforum.org	Overall project management

All contacts can be reached at National Quality Forum's office on 202-783-1300.