NATIONAL QUALITY FORUM

Meeting Summary

Contract No. HHSM-500-2012-00009I – Task Order HHSM-500-T0004

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

Meeting Summary

The National Quality Forum (NQF) convened an in-person meeting of the Population Health Framework Committee and the Field Testing Groups on April 14-15, 2016. An online archive of the meeting is available here.

Committee Member Attendance

Please see Attachment 1 for the list of Committee members in attendance.

Day 1 - Welcome, Meeting Objectives, and Agenda

Session led by Kaye Bender and Steven Teutsch, Population Health Framework Committee Co-Chairs.

Dr. Bender and Dr. Teutsch welcomed the Committee, Field Testing Groups (FTGs), federal liaisons, and virtual participants to the meeting. Elisa Munthali, Vice President, NQF, also provided a general welcome.

Dr. Bender reviewed the following meeting objectives:

- Discuss key lessons that emerged during the project in the areas of communication, partnerships and collaboration, sustainability, and measures and priorities
- Explore how measures used by Field Testing Groups align with national measure sets
- Examine how FTGs select measures to match organizational priorities
- Consider use of data sets and availability to achieving measurement goals
- Summarize how this project informs the national discussion and how this work continues to evolve

Dr. Teutsch gave a brief overview of the day 1 agenda.

Opening Remarks

Remarks were provided by Nancy Wilson, Government Task Lead, Agency for Healthcare Research and Quality (AHRQ) and Marcia Wilson, Senior Vice President, NQF.

Nancy Wilson noted the importance of the National Quality Strategy's (NQS), which is guided by the three aims to provide better, more affordable care for individuals and the community. These three aims are also the foundation for the National Quality Forum's priorities. The Population Health Framework project was informed by the NQS, the Health and Human Services (HHS) legislative mandate, NQF's Jacobson & Teutsch research paper, and NQF's interest in advancing this work. Dr. Wilson emphasized the goal of this project to address the need for a multistakeholder approach to population health improvement, to agree on common set of definitions and a framework for creating healthy people and

healthy communities, and expand the ability of the federal government to support population health improvement work.

- Upon completion, the Action Guide will be posted on federal websites and sent out via listservs with the goal to make the resource accessible to communities across the country.
- The results of this project, including input to the Action Guide, will be used to inform alignment of national efforts that are focused on creating measurement frameworks for population health improvement and to increase the meaningfulness of data to support population health measurement at the local, regional, state and national levels.

Marcia Wilson recognized the importance of the Action Guide as a robust and useful tool to assist communities in population health improvement work. Dr. Wilson also encouraged the project Standing Committee, FTGs, and federal partners to consider and discuss the practical next steps of this work so that the ideas can be discussed among the federal partners.

Project Background and Evolution

Session led by Leslie Vicale, Project Manager, NQF.

Ms. Vicale reviewed NQF's goals to reach consensus on broad issues through multistakeholder engagement. The Action Guide is one of several population health-centered projects at NQF that is grounded in the NQS, focuses beyond the medical model, addresses measure gaps, and exchangesideas among communities. After two successful project years creating and refining the Action Guide, the FTGs provided additional feedback on the use of measures and data that support their community health improvement work. Through a series of conference calls, key lessons were identified among the FTGs to be further explored during this meeting.

Panel Presentations

Communication

Session led by Rahul Gupta, Committee Member

Featuring FTG members: Laura Ross-White from the Community Service Council of Tulsa, Torney Smith from the Empire Health Foundation, and Mary Kushion from the Michigan Health Improvement Alliance.

Dr. Gupta framed the importance of audience-specific communication that should be customized for traditional and non-traditional stakeholders. This is important to demonstrate an understanding of various perspectives and to get stakeholders actively involved in decision-making. The FTGs provided the following insights:

- Communication using agreed-upon, culturally-sensitive terminology is critical to engaging stakeholders to move forward and to create an inclusive space, such defining what a healthy community is, using "community indicators" instead of social determinants, and explaining public health acronyms.
- Identifying goals up front is important— this ensures partners understand expectations and build communication into the overall collaborative strategy.
- Working through community members, such as community health workers, to communicate objectives, interventions, and data "connects the unconnected" in a trusted way and for non-public health stakeholders to understand the importance of population health improvement initiatives.
- Community members are "waiting to be asked" and will welcome the opportunity if invited.

- Give options for the level of communication by allowing stakeholders to receive all notifications, or choose to receive only what they are most interested in.
- The use of technology, such as webinars and social media, can increase engagement with stakeholders. Focus groups can also help stakeholders understand messaging that is most effective and relevant.
- Partnering with local university communications departments can also achieve communication goals.
- Having a "champion" in faith-based communities can help reach a large number of individuals that spend more time in faith gatherings than in the doctor's office.
- Developing a shared narrative is important, especially to explain that health is more than health care.
- Measures and metrics can be used to help show the impact of population health interventions—communicating success increases interest and expands interventions into other areas.
- When convening stakeholders, it can be helpful to do so without using formal titles such as "Doctor Smith"; this can unintentionally create hierarchial relationships between stakeholders, which can make it difficult for some community members to feel comfortable sharing thoughts and ideas.
- It is important how one communicates the desire to focus on health; the idea of "changing the culture of health" can be threatening or misinterpreted, as it implies that one's 'culture' is wrong or needs to be changed. Culture is a very personal concept.
- NQF's "ABCs of Measurement" is a useful tool to help stakeholders better understand measurement since many are not familiar with it.
- There is an opportunity to communicate how population health improvement work helps health systems meet goals for Accountable Care Organizations (ACO) and value-based payment models. Collaboratives can leverage local knowledge and data to keep health systems engaged, with reference to incentives from the Centers for Medicare and Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI), Health Resources and Services Administration (HRSA), and ARHQ which encourage hospitals and medical groups to focus on population health improvement.

Partnership and Stakeholder Collaboration

Session led by Shelley Hirshberg, Committee Member
Featuring FTG members: Melissa Cullum from the Geneva Tower Health Collaborative, Judy Crabtree from the Kanawha Coalition for Community Health Improvement, and Brenda Battle from the University of Chicago Medicine Population Health Management Transformation

Ms. Hirshberg framed the topic by noting that population health improvement is challenging and requires collaboration to achieve goals. A shared vision must be at the center so stakeholders can connect the work to their organizations. Inviting the right partners to the table is critical to capturing the various resources needed to fulfill initiatives. The FTGs provided the following insights:

- Building trust with partners takes time and trust can lead to a wealth of information. For example, trusted partners may be able to accesss to data on social determinants of health that impact health outcomes from non-traditional stakeholders such as police departments and public schools.
- Consider the various stakeholders needed at the table when the collaborative is beginning its work.

- When there is turnover in the leadership of key partner organizations, you must build a relationship with the successor.
- Do not force the collaborative's own needs above partner organization needs: ensure the outcomes are mutually beneficial to all participants — play toward the "what's in it for me" mentality.
- Sharing health risk factors and priority areas from a Community Health Needs Assessment (CHNA) with partners is a way to ensure that stakeholders understand the greatest needs of individuals as driven by the community.
- Meeting partners and stakeholders where they are and slowly influencing their behaviors over time works best, particularly the individuals targeted to receive interventions.
- Creating local resident "champions" can be effective in engaging participants.
- Galvanizing stakeholders behind a large initiative can bond groups together and and cultivate a desire for collective success; highlighting attainable, short-term measures ("meet-able" goals) can maintain positive engagement.
- It is helpful to identify competition or potential conflicts early and mediate those as needed; partnerships can resolve issues quicker than investigations.
- Selecting and using measures can build stakeholder buy-in and increase program transparency. Making measure lists and information about definitions available online can help stakeholders highlight the value of the work and identify potential gaps.

Sustainability and Working through Evolution

Led by Anne De Biasi, Committee Member

Featuring FTG members: Kimberly Libman from Designing a Strong and Healthy NY, Cynthia Andrews and Silas Buchanan (virtually) from Oberlin Community Services, and The Institute for eHealth Equity, and Alison Carl-White from the Empire Health Foundation

Ms. De Biasi framed the importance of this panel topic by stating that sustainability is about more than funding— it includes adaptability and resilience. Change is constant— funding, priorities, staff, etc. Sustainability can also involve making policy or environmental changes that can have a long-term impact on the communities being served. The FTGs provided the following insights:

- Shifting priorities to meet the dynamic needs of the community can impact how to successfully interact with local and state government.
- For newer collaboratives, being structured yet creative with state dollars is important.
- Ability to adapt is important to continue to meet people where they are— using technology can shorten the distance between the individual and the health system or resources.
- State and federal objectives can play an important role in the collaborative's focus.
- The Affordable Care Act created several opportunities to advance population health improvement. This includes CMMI grants to more quickly integrate solutions into communities.
- Various skills are needed to ensure sustainability such as grant writing, ability to translate unique community knowledge to stakeholders, and ability to leverage resources across programs.
- While sustainability is not only about funding, when funding sources end, priorities may need to shift to transition to the next source of funding.
- Aligning priorities of the collaborative with the interests of funders can be challenging. It is important to be opportunistic, use available funding, remain transparent about goals, and to emphasize the influence that collaboratives can have on state-level outcomes.

- Creative private-public partnerships can help connect available resources. Examples include: the Community Service Council of Tulsa asked Boppy Pillows for donations and Tulsa received pillows for breastfeeding moms; DASH-NY has partnered with an architectural firm and local government leaders to build a policy plan to bridge urban development and population health, and a local health department in the service area of the Empire Health Foundation organized an event during Christmas for children to receive immunizations.
- Relationships in small communities, where everyone knows each other, can have a positive impact on public-private partnerships and social capital.
- Sustaining commitment requires an emphasis on alignment and where stakeholder interests intersect. Define how the "asks" are related and ensure that this information is documented.

Measures and Priorities

Led by Keith C. Kosel, Committee Member
Featuring FTG members: Laura Ross-White from the Community Service Council of Tulsa, Gregory Paulson from the Trenton Health Team, and Camille Harding from the Colorado Cross-Agency Collaborative

Dr. Kosel framed the panel topic by stating that population health is evolving. As mandates increase and reimbursement is increasingly tied to keeping populations healthy, it is becoming a higher priority. Demonstrating measureable impact at a local level remains a challenge and is needed to achieve full-scale implementation across the health ecosystem. The FTGs provided the following insights:

- One FTG noted that they rely on a variety of frameworks to show alignment of measures, including the NQS and the Institute for Health Improvement (IHI) reports .
- Measures can be used to legitimize the work of collaboratives and other non-profits, especially in the view of providers.
- Health Information Exchanges (HIE) can connect data from providers between urban and rural settings and to share common measure results.
- An FTG that is also an Accountable Care Organization (ACO) was required to report the results for several metrics. Since many do not align with the FTG's top priorities, they needed to prioritize measures. Choosing a small number of metrics tied to particular projects allowed them to show meaningful impact over time.
- One FTG selected a single set of measures to be used across several state agencies. The measures align with intended outcomes and reflect where services are being delivered.
- Older collaboratives may have a robust amount of historical data that can be used to show trends and impact over time.
- In some places, an abundance of data is held in HIEs that are regionally focused, making it difficult to select measures and communicate results effectively across multiple regions.
- Recognizing alignment of priorities among partners helps identify measures that can be tracked by the collaborative. This underscores the importance of shared goal-setting in the strategic planning process.
- Observations about the measure selection included:
    - Choosing measures that are also important to the local health care system can align local efforts and further legitimize a collaborative's work.
    - Measures that correlate to available data (such as state-level Medicaid data) allow collaboratives to assess improvement for the entire state.

    - Measures that can show improvement in a shorter period of time, such as prenatal care and infant mortality, versus longer-realized results like obesity and chronic diseases, are helpful to highlight the impact of collaborative work.
- Not identifying an agreed-upon taxonomy within electronic health records (EHR) is a challenge. To support improvement, EHR information should be readily available and communicated in a meaningful way for providers to make appropriate decisions when treating individuals. It would be helpful to figure out how these systems can also be used to communicate social determinants of health, such as availability of healthy food, and rates of homelessness and domestic violence, but these systems are not yet linked. A collaborative can be an intermediary that pushes and pulls data, especially for non-covered entities, helping to alleviate this issue.
- Educating providers about what affects measure results is important. For example, collaboratives can demonstrate that providers are not routinely directing patients to the emergency room (ER) to receive care, if there are other appropriate options available such as urgent care centers or walk-in clinics.

During the discussion, Committee and FTG members made a variety of comments regarding the value of the depth and breadth of these panel discussions from individuals who are actually working on population health improvement in their communities.

Population Health Measurement on a Broad Level

Session led by David Stevens, Committee Member and Diane Stollenwerk, NQF project consultant

Dr. Stevens noted that several frameworks for population health measures are being developed or promoted at a national level. He provided an overview of the framework included in the Institute of Medicine's (IOM) Vital Signs report, which includes suggested core metrics for progress on population health improvement.

- The IOM criteria for the core measure domains included: Importance for health, strength of linkage to progress, understandability of the measure, technical integrity, potential for broader system impact, and utility at multiple levels.
- The criteria for the core set of measures included: systemic reach, outcomes oriented, person meaningful, parsimonious, representative, utility at multiple levels. (The measure set includes four key domains and 15 specific measures.)
- The IOM report emphasizes health disparities throughout.
- While the IOM Vital Signs domains and measures are at a national level, more work needs to be done to enable them to be used at the state, regional or local levels.

Ms. Stollenwerk described how the ten FTGs have done tremendous work to help NQF understand the measures that they are using. The information provided to NQF by each FTG includes and is not limited to the measure name, level of analysis, data source type, and specific data source.

- Last contract year, the project Committee directed NQF to focus on the IOM Vital Signs report, which is why it was used as the framework to analyze the 478 measures identified by the FTGs.
- Based on mapping the FTG measures to the IOM domains, the top three categories were Healthy Behaviors (81), Healthy Social Circumstance (61), and Appropriate Treatment (59). Person-Centered Care had the fewest measures (1), as well as Affordability (4).

- No measures for overall spending are currently being used by the FTGs. Questions about how to determine 'overall' spendingfor a multisectoral approach likepopulation health improvement can be difficult to address.
- Many measures being used by the FTGs do not fit into the IOM Vital Signs domains (65). These addressed areas such as Effectiveness and Outcomes of Stakeholder Collaboration and Health Care Facility Referral or Use Rates, among other topics.

Meeting attendees discussed how the key lessons from this analysis could further inform future population health measurement work. There was agreement that such measures should be considered for endorsement by NQF. However, parsimony of an endorsed or recommended set of population health measures may make it difficult for communities to select measures that represent their priorities. One suggestion was to identify composite measures at the national level, as a roll-up roll-down approach, so that the most relevant sub-measures of the composites could be selected and used within each community.

Population Health Measure Domains: A Combined Federal Effort

Session led by Denise Koo, Centers for Disease Control and Prevention

Dr. Koo provided a brief overview of federal efforts to address the need for a set of population health measure domains. This includes the National Center on Vital Health Statistics (NCVHS) Population Health Subcommittee to inform the Assistant Secretary of Health and Human Services (HHS) regarding an initiative called Public Health 3.0.

- The goal of Public Health 3.0 is to identify 10-12 domains that advance multi-sectoral collaboration to improve community health and well-being.
- The question is: what is a healthy, safe and thriving community and how to measure that? The project was focused on identifying metrics with health as the primary focus, cross-cutting beyond health care, and inclusive of social determinants.
- The NCVHS Population Health Subcommittee was interested in useful and feasible community-level metrics that drive state or local strategies and bring people together.
- Other federal agencies, such as the Department for Housing and Urban Development (HUD), are already advancing evidence-based metrics that are cross-cutting. These frameworks should be considered by the health sector.
- The work of the NCVHS subcommittee is being refined to balance local measure flexibility with national comparability. The subcommittee is also considering measures throughout the life-course.

Measurement Discussion Breakout Session

Committee members and FTGS participated in a breakout session to discuss how the FTGs select measures and some of the challenges they face. Reflections from the breakout session include:

- The need for more timely, granular, and person-centered data.
- The difficulty of using a framework when funding dictates what must be measured. Multiple funders and/or agencies may be requesting the use of measures that are not aligned with each other or the framework. Upstream prevention measures can be limiting and measures selected by funders are often very health care or clinically-centered.

- Data limitations include: inability to access mental health data and lack of integration with other health care data, and measure data needs and differences at the individual personal level versus the level of the family unit.
- Policy improvement is not easily reflected through the use of measures. Quality of engagement and the impact of consensus building are also difficult to measure.
- Health care quality and value-based purchasing metrics often are prioritized over other topics and drive what is addressed in the short term.
- The ability to share information across the community and use the same set of common terms and definitions would make population health work more effective and efficient.

Measure Selection Exercise

Session led by Matt Stiefel, Committee Member and Elisa Munthali, NQF Vice President.

Ms. Munthali framed the session by stating that using a logic model or framework can be helpful to determine which measures best reflect the impact of population health improvement work.

- Mr. Stiefel presented an exercise that he used while on the site visit to the Colorado Cross-Agency Collaborative FTG, which could be applicable to all the FTGs and other collaboratives working on population health improvement.
- He used the 100 Million Healthier Lives (supported by the Institute for Healthcare Improvement) framework as the foundation for measure selection.
- Mr. Stiefel explained that It is important to first define “how much and by when” then reviewed how driver diagrams can identify which measures relate to outcomes, showing a causal pathway, and emphasizing the theory of change.
- Individual level measures can be rolled up to aggregate level measures; however, community level measures cannot be disaggregated to understand health issues at the individual level.
- An interactive tool, called the “Metrics that Matter Wizard”, to guide measure selection is also being developed to assist communities.

The Colorado Cross-Agency Collaborative (CCAC) FTG described the insights they gained from the measure selection exercise done with Mr. Stiefel during the 2015 site visit.

- Camille Harding reviewed the logic model CCAC used for selecting measures, starting with the NQS triple aim; CCAC’s goal is to provide access to comprehensive health care that integrates physical and behavioral health using value-based payment models for 80 percent of Coloradans .
- The Colorado State Innovation Model (SIM) grant required the use of measures involving the number of beneficiaries receiving care, including measures focusing on topics such as all-cause readmissions, psychiatric readmissions, total cost of care, and substance abuse disorder composite.
- Chris Underwood explained that the health information technology goal is to collect as much data as possible into one data set in order to create a data set across the entire state. Regression analysis can then be performed to show causation and identify interventions that are having the desired outcomes.
- Building improved data infrastructure came out of the EHR technology governance model and was accomplished by investing funding from Medicaid. A remaining issue with interoperability is protecting and safely sharing data, which requires building trust with partners.
- Political issues, such as migration of populations, can influence measurement when data lags and cannot reflect changes in a timely fashion. To understand what is affecting data, you must

consider what occurred during the timeframe reflected in the data. This will enable you to try to control for those variables and mitigate the impact.
- An important part of data analytics is to assist end-users in understanding what the data mean.

Day 2 - Welcome, Meeting Objectives, and Agenda

Session led by Kaye Bender and Steven Teutsch, Population Health Framework Committee Co-Chairs.

Dr. Bender and Dr. Teutsch welcomed the Committee, Field Testing Groups (FTGs), federal liaisons, and virtual participants to the second day of the meeting.

Dr. Teutsch reviewed the meeting objectives as listed on page one of this summary.

Dr. Bender gave a brief overview of the day 2 agenda.

Data Sources: Essential Yet Varied

Session led by Leslie Vicale, NQF Project Manager and Diane Stollenwerk, NQF Consultant

Ms. Vicale reviewed the various levels of health data collection and influencing factors. While there are many known data sources, it is important to identify useful, usable and appropriate data sources to calculate population health measure results.

Ms. Stollenwerk then summarized the analysis performed on the data sources used by the FTGs which ranged from federal sources, such as the Behavioral Risk Factor Surveillance System (BRFSS), to local sources, such as health department and school system data. Several challenges about data source use were identified by the FTGs:

- The skills and time needed to access the various data resources was noted as a particular issue for many groups since their time and budgets are always limited.
- The granularity of data is an issue in many communities. Although accredited local public health departments may be able to fill some gaps, neighborhood-level data are often unavailable or unattainable.
- A number of measures identified by the FTGs had no data source listed or the source was generic, such as “survey.”
- Much of the data available through reputable sources are at the county-level while other more granular data sources may not be timely enough to be useful.
- Regarding the sharing of data sources, the tension between collaboration versus competition plus the issue of politics between profit and non-profit entities were discussed. Making the business case for working together to share data is an important part of the work for some FTGs.
- Data Use Agreements and open communication between groups regarding appriopriate access to data can help overcome Health Insurance Portability and Accountability Act (HIPAA) privacy concerns and more restrictive laws in some states.

The Committee and FTGs offered additional perspectives on data sources and innovative ways to use them:

- Many FTGs were able to use several national data from sources such as US Census, BRFSS, Bureau of Labor Statistics, Department of Justice, Department of Education, Food and Drug Administration, HRSA, and CDC, among others.
- Other FTGs discussed their use of data from state or local sources, such as police departments, school districts, and transportation departments.
- Using ACOs as allies can be helpful in gathering data since ACOs are often driven more by health-related data than some of their health care counterparts.

Data Discussion: Breakout Session

Committee members and FTGS participated in a breakout session to discuss the usefulness of data and issues regarding data granularity. Reflections from the breakout session include:

- People need affordable, accessible, and usable data that are relevant at the local level. Ideally, data: would have geographic specificity, like information at the neighborhood block level; promote and support collaboratives; be useful to identify members of the community and differentiate among individuals and subgroups; enable analysis by household and family unit; and, include clear definitions.
- Data that are standardized or consistent across communities would enable sharing of online electronic health data and support collaboration and access to timely data. This would also reduce the amount of duplicative data currently being collected.
- To increase the usefulness of data, the collection methods, community statistics, and scale of the data should be clear.
- National standards for data collection could help streamline the process and help with the limited capacity of state and local groups to collect data.
- The collection and use of data to define minority populations, including race, ethnicity, language, disability and/or LGBT status was discussed in depth. In addition to collecting the data element, it is also important to analyze cultural characteristics.

Federal Data Sources Discussion

Session led by Kaye Bender, Committee Co-Chair

Committee Members, FTGs and federal liaisons discussed the use of federal data sources. Reflections from this session include:

- Telephone surveys have been a resource for gathering health information from the public. Although the results of these calls may be biased because of the declining use of landline telephones, being able to speak to the public directly has advanced measurement for many groups. However, the lack of landline telephones and presence of caller ID have severely lowered response rate.
    - Fear of bill collectors is another reason phones are often unanswered. Because of this, one FTG opted instead to set up tables at housing community meetings to gather input via surveys.
    - Reaching people through text messages is a new way to engage people with messaging and reminders. It is also being tested as a way to gather small amounts of information from the public.

- "Big data" are increasingly used: integrating population health data into electronic medical records could help connect public health with health care system perspectives and efforts.
- County or local health departments help gather race and gender data. Attendees discussed the importance of allowing individuals to self-identify their own race and gender.
- County, state, and federal level data all starts at the most granular level. In the past, granular data was not accessible and needed to be aggregated to a larger denominator to be useful. Perhaps this approach is outdated and now data should be maintained at the granular level then "rolled up" to higher levels when needed.

Using BRFSS as a case study, Dr. Bender asked how it could be more useful for assessing population health improvement.

- Certain federal data sources, such as BRFSS, provide information at a county level that cannot be found anywhere else.
- Although federal data sources contain large amounts of information, the data cannot always be manipulated in ways that are useful to local, state or regional efforts.
    - Some federal data sources are easier to manipulate, such as the Centers for Disease Control and Prevention data and Youth Risk Behavior Surveillance System.

Future of Population Health Measurement

Session led by Marcia Wilson, NQF Senior Vice President

Dr. Wilson described the "bigger brain" theory and asked participants to share their thoughts and ideas as national problems often require solutions from the local, state and regional levels. She asked for input on these questions:

- Where should this work on the Action Guide go based on what we know? What are the concrete next steps? What would each FTG and Committee member do next to move this forward in the local, state, and national level?

Insights from Committee and FTGs discussion include:

- Moving forward, it would be preferable for measures to drive the development of data sources instead of measures being created because less-than-ideal data are available. Conversations about how best to "roll-up and roll-down" data could foster relationships and encourage learning for everyone.
- The lack of access to useful data was discussed again, and reinforced by all attending as a critically important issue to the future of measurement and population health improvement.
- In an age where so much information is gathered, available and used – especially by industry giants such as Google and Amazon – where should the line be drawn for what to share regarding the factors that affect health (ie., social determinants and health care)?

NQF Member and Public Comment

Comment: Dalana Ostile from Providence Health System stated, "In regard to our hospitals and their use of databases, in our case nothing is harmonized."

Project Timeline and Next Steps

- NQF staff will revise the draft Action Guide with input from the FTG conference calls and the April 14-15, 2016 in-person meeting.

- The public comment on the draft Action Guide report will be from mid-May until mid-June.
- The next and final public web meeting will occur on July 7, 2016.
- The Action Guide 3.0 will be submitted to HHS on August 1, 2016 and will be posted on the NQF website for the public.

Attachment 1

Task 4 Population Health Framework Committee in Attendance
April 14-15, 2016 Web Meeting

Population Health Framework Committee Members
Kaye Bender, Co-Chair
Steven M. Teutsch, Co-Chair
Catherine M. Baase, The Dow Chemical Company
Georges C. Benjamin, American Public Health Association
Scott D. Berns, National Institute for Children's Health Quality
Kevin L. Bowman, Anthem, Inc.
Debra Burns, Minnesota Department of Health
Anne De Biasi, Trust for America's Health
Susan L. Freeman, America's Essential Hospitals
Rahul Gupta, West Virginia Department of Health and Human Resources
Shelley B. Hirschberg, Leadership Coach & Social Entrepreneur
Keith Kosel, Vizient, Inc.
J. Lloyd Michener, Duke University Medical Center
Doriane Miller, Center for Community Health and Vitality of the University of Chicago Medical Center
David Nash, Thomas Jefferson University
Jeremy Sanders, Common Table Health Alliance
David Stevens, Milken Institute School of Public Health, George Washington University
Matthew Stiefel, Kaiser Permanente
Julie Trocchio, Catholic Health Association of the United States
Population Health Framework Field Testing Group Members
Camille Harding, Colorado Cross-Agency Collaborative
Christopher Underwood, Colorado Cross-Agency Collaborative
Laura Ross-White, Community Services Council of Greater Tulsa
Jan Laverne Figart, Community Services Council of Greater Tulsa
Rebecca Abraham, Designing a Strong and Healthy NY
Kimberly Libman, Designing a Strong and Healthy NY
Alison Carl White, Empire Health Foundation
Torney Smith, Empire Health Foundation
Judith M. Crabtree, Kanawha Coalition for Community Health Improvement
Brenda Grant, Kanawha Coalition for Community Health Improvement
Melissa D. Cullum, Geneva Tower Health Collaborative
Megan Vranish, Geneva Tower Health Collaborative
Mary Kushion, Michigan Health Improvement Alliance
Beth Roszatycki, Michigan Health Improvement Alliance

Cynthia H. Andrews, Oberlin Community Services and the Institute for eHealth Equity
Silas Buchanan, Oberlin Community Services and the Institute for eHealth Equity
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