National Priorities Partnership

Convened by the National Quality Forum

POPULATION HEALTH CONVENING MEETING

SYNTHESIS REPORT

MAY 2010

NATIONAL PRIORITIES PARTNERSHIP

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SYNTHESIS REPORT

This meeting was conducted as part of the ongoing efforts of the workgroups of the National Priorities Partnership with the purpose of identifying environmental barriers to achieving the goals of the Population Health priority area and developing a plan to address them; identifying critical measure gaps; and addressing implications for health information technology. This report provides a high-level synthesis of the meeting results.

I. INTRODUCTION

In its 2008 report, *National Priorities & Goals – Aligning Our Efforts to Transform America's Healthcare*,[1] the National Priorities Partnership (NPP) identified six National Priorities that if addressed would significantly improve the quality of healthcare delivered to Americans. In an effort to look beyond the walls of the healthcare delivery system, NPP identified Population Health as one of the six Priority areas, reflecting an increased awareness that only a small percentage of overall health comes as a result of care delivered through traditional healthcare services.

It is not enough, however, simply to identify Priorities for national action. In order for change to take place, action must follow. To address the Goals of each Priority area, in 2009 NPP established individual workgroups to provide guidance for the development of comprehensive action plans to drive change. In response to this charge, the Population Health workgroup convened a meeting of key stakeholders on February 17-18, 2010, in Washington D.C. The goal of the workshop was to develop specific actions for NPP Partners and others to consider – actions that if implemented would have the greatest potential to meet the three overarching Population Health Goals that:

- ✧ All Americans will receive the most effective preventive services recommended by the U.S. Preventive Services Task Force.
- ✧ All Americans will adopt the most important healthy lifestyle behaviors known to promote health.
- ✧ The health of American communities will be improved according to a national index of health.

In developing their respective action plans, all workgroups have embraced a three-part strategy that includes:

- ✧ Identifying environmental barriers to achieving the Goals and developing a plan to address these barriers through drivers of change (e.g., payment systems, public reporting, performance measurement, accreditation and certification, research and knowledge dissemination, and system capacity);
- ✧ Identifying measure gaps and developing a plan for filling high-priority gaps; and
- ✧ Addressing implications for health information technology (HIT), including data collection needs, data reporting, and decision support tools.

This report provides a high-level synthesis of the workshop including identified drivers and high-leverage action steps for NPP Partners and other stakeholder groups that promote shared accountability and stimulate change. Key measure gaps are identified along with

issues for consideration for future measure development, endorsement, and implementation efforts. Finally, given the critical role of HIT in any healthcare efforts moving forward, important issues relate to the integration of data sources and alignment with the meaningful use agenda are presented.

II. Drivers of Change and Moving Toward Action

Informed by workshop presentations that provided a synthesis of evidence regarding high-leverage interventions for the promotion of clinical preventive services and healthy lifestyle behaviors, participants identified a menu of action steps to be taken across stakeholder groups—emphasizing partnerships—with the overarching goal of improving the health of the population.

Participants focused on NPP "drivers" of change—payment systems, public reporting, performance measurement, systems capacity, education and certification, and research and knowledge dissemination[2]—and through a facilitated, iterative group process identified which drivers and associated actions had the maximum potential to "move the needle" toward desired outcomes. To follow is a succinct synopsis of the action plan formulated by the group; Table 1 provides a snapshot of the recommended actions.

Clinical Preventive Services

Key drivers identified to mobilize widespread uptake of clinical preventive services include: (1) implementing an "opting out" system design principle; (2) initiating broad-based payment reform that creates incentives for preventive services; and (3) creating a Clinical Preventive Services Index performance metric.

Driver: System Capacity

The concept of an "opting out" design principle was embraced by the group as a mechanism to make the default for employee selection of health benefits the "healthy option" choice; this would essentially require an employee to consciously "opt out" from a plan that ensures mechanisms are in place (e.g., prompts embedded into electronic health records), to remind providers when age- and sex-appropriate screenings are due. Further supporting this type of a strategy, it was proposed that tools and incentives would be available to individuals to facilitate tracking and remaining up-to-date on clinical preventive services—to relieve the burden of tracking a battery of separate interventions. Such a design could be tied to incentives, both for individuals and providers, as part of value-based purchasing and benefit design. Another proposed approach was to replicate best practices in the field that also use an "opting out" tactic, such as standing orders for immunizations. Instituting standing orders for pneumococcal vaccination in one hospital demonstrated an increase in the delivery rate of vaccinations from 0 to 78 percent among persons 65 years of age and older or at high risk.[3] The associated action steps needed to implement this strategy will clearly require coordination among multiple stakeholder groups including clinicians so they can be more effective agents of change for prevention and health promotion, and private purchasers, employers, health plans, providers, and consumers among others. Additionally, the expectation is that consumers will have the necessary information to understand their various options and make the best choices based on their personal preferences.

Driver: Payment

Supporting policy changes, specifically the redesign of payment models to incent the delivery of high-priority clinical preventive services, was identified as a primary driver of change and a central rallying point for action. One strategy is to offer defined payments to providers with the goal of improving preventive service rates for the top areas identified by the National Commission on Prevention Priorities,[4] such as childhood vaccination series execution; tobacco cessation counseling with assistance; and problem drinking screening and brief counseling. Current examples of this approach include: at the federal level, reimbursement for tobacco cessation counseling under Medicare[5], and at the state level, coverage under the Massachusetts Medicaid program.[6] It is estimated that by increasing tobacco cessation counseling from its current utilization rate of 35 percent to 90 percent approximately 1.3 million quality-adjusted life years (QALYs) could be saved.[7] Execution of this strategy will require the collective effort and commitment of public and private purchasers, insurers, public health agencies, and others to ensure first dollar coverage for preventive services. Additionally, further exploring nontraditional delivery approaches, such as payment for preventive services delivered by nonphysicians, could further promote the delivery of these services without further burdening primary care.

Driver: Performance Measurement

Performance measurement was viewed as foundational to monitoring progress toward the achievement of the NPP Population Health Goal that "all Americans will receive the most effective preventive services recommended by the U.S. Preventive Services Task Force," and to increasing transparency and accountability through public reporting. Importantly, performance measurement is a tool that supports quality improvement efforts, serving as a feedback mechanism that allows providers, health systems, communities, and national efforts to channel energy and resources toward interventions that address areas of most need—as part of a continuous learning system. Participants called for a "Clinical Preventive Services Index" (CPSI), a composite measure of high-impact services that would be stratified by life stage and gender, which ideally could be rolled up from an individual to a population level. Key players for advancing and operationalizing this action item include measure developers, NQF, Quality Alliances, public and private funders, accrediting bodies, and others. The CPSI and its components will be further discussed in the upcoming section related to measure gaps.

HEALTHY LIFESTYLE BEHAVIORS

The prominent drivers identified for healthy lifestyle behaviors intersect with those of the clinical preventive services described above, thus favoring an integrated approach toward implementation that builds on these similarities as opposed to a disparate path. Resonating themes for healthy lifestyle behaviors, as with clinical preventive services, included the adoption of a systemic approach across settings, a call for payment reform, and a foundational role for performance measurement. Explicitly, consumer engagement addressed through messaging around healthy lifestyle behaviors received considerable attention from the group.

Driver: Consumer Engagement

Workshop participants agreed that engaging consumers as active participants in their health would need to be a core component of any action plan put forth. Recognizing the consumer's

critical role in self-management, communication emerged as a prominent theme, particularly in regards to messaging around healthy lifestyle behaviors.[1] There was general consensus that current messaging pertaining to the adoption of effective evidence-based healthy behaviors has fallen short, and as such consumers are receiving inconsistent messages. Moreover, the group believed that the right message has not yet been solidified, and that therefore the development and testing of a targeted social marketing and media effort is warranted. Providers also must have the necessary tools to assist in conveying these messages. Stakeholders to engage for this driver include consumer groups, providers, public-sector agencies, and others.

Driver: System Capacity

Attaining the NPP Goal that "all Americans will adopt the most important healthy lifestyle behaviors known to promote health" will require a systemic approach using multiple methods including public policy, community development, and healthcare delivery system approaches. For example, public policy-oriented interventions to encourage healthy food choices might include making unhealthy food options more expensive or increasing access to fresh fruits and vegetables in underserved neighborhoods. Physical activity may be promoted through community development strategies, such as land-use planning for parks and sidewalks. Linkages to appropriate community resources may be made more available to clinicians—in an effort to bridge the healthcare delivery system more deliberately with public health—so that they are able to be more effective agents for prevention and promotion. Collectively, these interventions will require expanding beyond the traditional walls of healthcare including into the workplace, schools, and local communities, and engaging stakeholder representatives from each of these areas. A key focus of the engagement of these entities should be to collaborate to align messaging and programs for consistency between them and healthcare stakeholders.

Driver: Payment

As with clinical preventive services, providing incentives and first dollar coverage to encourage healthy lifestyle behaviors was viewed as an essential component of a multifaceted systems approach to achieving and rewarding results. Incentives could emanate from multiple levels and be directed at individuals, providers, health plans, employers, and public health agencies. For example, health plans and health insurers (public and private) could provide incentives to individuals (e.g., employees and beneficiaries) to increase the adoption of healthy behaviors. Health plans, working closely with providers, could share performance data, which would be coupled to value-based payments, and working collaboratively with each other could send unified market signals to promote aligned data collection and sharing. And employers could potentially leverage performance on healthy lifestyle metrics in their contract negotiations with health plans. Additionally, on a macro level, public health agencies could be rewarded for implementing evidence-based interventions to address improvements in the health determinants in their local jurisdictions.

Driver: Performance Measurement

As above, participants called for a "Healthy Lifestyle Index" (HLSI), a composite measure of core behaviors that would be stratified by life stage and have the capacity to roll up from the

[1] Because of the importance of consumer engagement to the adoption of healthy lifestyle behaviors, this was added as an additional driver; consumer engagement is not identified as a major driver in the initial NPP framework.

individual to the population level. The HLSI and its components will be further discussed in the following section related to measure gaps.

Table 1
National Priorities Partnership
Population Health Comprehensive Action Plan

	Drivers			
	Consumer Engagement	***System Capacity***	***Payment***	***Performance Measurement***
Actions	Develop and test a targeted social marketing and media effort that pertains to effective evidence-based healthy behaviors to target the inconsistent messaging that consumers currently receive. Ensure that providers have tools and resources to assist consumers in adopting key healthy behaviors.	Develop interventions to encourage healthy food choices (e.g., increasing prices on unhealthy food options). Promote community development strategies that encourage physical activity (e.g., through land-use planning). Provide clinicians with necessary linkages to community resources to bridge the healthcare and public health systems. Develop tools and incentives that enable and encourage individuals to easily track and stay up-to-date on necessary clinical preventive services (e.g., prompts within electronic/personal health records). Modify benefit design and programs to default to the healthiest option available for individuals (an "opting out" strategy similar to standing orders).	Redesign payment models that direct incentives for the promotion of healthy lifestyle behaviors at the level of the: ✧ Individual (e.g., through beneficiary incentives); ✧ Provider (e.g., through value-based payments); ✧ Health plan (e.g., through the sharing of performance data); ✧ Employer (e.g., through contract negotiations to include healthy lifestyle metrics); ✧ Community and public health agencies (e.g., through improving performance on health determinants). Redesign payment models to provide first dollar coverage and direct incentives to clinicians for the delivery of high-priority clinical preventive services as identified by the National Commission on Prevention Priorities (e.g., reimbursement for tobacco cessation counseling).	Develop a "Clinical Preventive Services Index" (CPSI) and "Healthy Lifestyle Behaviors Index" (HLBI), as composite measures that would be stratified by life stage and could be rolled up from an individual to a population level. Champion recently released community health rankings as a call to action for all stakeholder groups responsible for addressing community health needs. Further identify opportunities for refining a community ranking or index (e.g., for trending, increased granularity), and expanding the evidence base of actionable interventions that drive improvement.
Implementers	✧ Consumer groups ✧ Healthcare professionals and providers ✧ Health plans ✧Public and private purchasers	✧ Communities and public health agencies ✧ Consumer groups ✧ Healthcare professionals and providers ✧ Health plans ✧ Public and private purchasers ✧ Policymakers ✧ Schools	✧ Communities and public health agencies ✧ Consumer groups ✧ Health plans ✧ Public and private purchasers	✧ Accreditors ✧ Measure developers ✧ NQF ✧ Public and private funders ✧ Quality alliances

III. POPULATION HEALTH MEASURE GAPS

Building on the discussions about key interventions and drivers of change, workshop participants identified critical measurement gaps to address in order to make progress on

improving population health. Of primary importance for all three NPP Goal areas is the development of composite measures that would drive the delivery of the most effective preventive services, promote the adoption of critical lifestyle behaviors, and provide a multifaceted assessment of overall health status at a population level.

CLINICAL PREVENTIVE SERVICES

Workshop participants advocated for the development of a composite measure of clinical preventive services—consisting of a parsimonious set of measures that map to high-impact interventions—with the individual elements being determined by their effect on morbidity, mortality, and promoting optimal health. To be most useful, it was recommended that the composite should be stratified by gender and life stage, as well as adjusted for risk factors inherent to disadvantaged subpopulations, to allow for more tailored and culturally sensitive interventions.

Several technical issues were raised by the group concerning the development of composites. Regarding methodological approaches for scoring composites, some favor an "all-or-none" approach versus a weighted composite. There was discussion of the value in separately reporting individual elements within the composite to enable providers to further discern and be judged on where they performed well or needed to improve. Whether or not individual elements of a composite should be weighted differently or the same was also debated. Although workshop participants did not come to a resolution on these issues, as this was outside the scope of the meeting, these topics do need further consideration moving forward. The National Quality Forum (NQF) has developed criteria for evaluating composites, which was informed by a multistakeholder steering committee, which can offer guidance in this area.[8]

Additionally, it was recommended that a system be in place for determining which measures are included or excluded from a composite that offers credibility with a broad group of stakeholders. Importantly, measures that are selected for inclusion in composites should be supported by the strongest level of evidence available such as the recommendations of the U.S. Preventive Services Task Force. This should be communicated in the Call for Measures. Significantly, as the evidence base changes over time, composite measures would undergo regularly scheduled measure maintenance to ensure that standards are current and are monitored for unintended consequences.

Finally, consideration also must be given to implementation issues so that providers are equipped with the tools and resources to improve their scores and most importantly health outcomes. This could entail system supports such as standing orders for appropriate clinical preventive services; adequate linkages between physician practices and other community resources to ensure care coordination; and data aggregation and sharing between healthcare and community settings. All groups must also have the necessary tools and resources to support the achievement of this goal, including among others consumers, employers, health plans, and public and community health agencies.

HEALTHY LIFESTYLE BEHAVIORS

Similarly, workshop participants agreed that a composite measure is needed for the most important healthy lifestyle behaviors that if adopted would have the greatest potential to decrease morbidity and mortality as well as lead to improved health status and increased

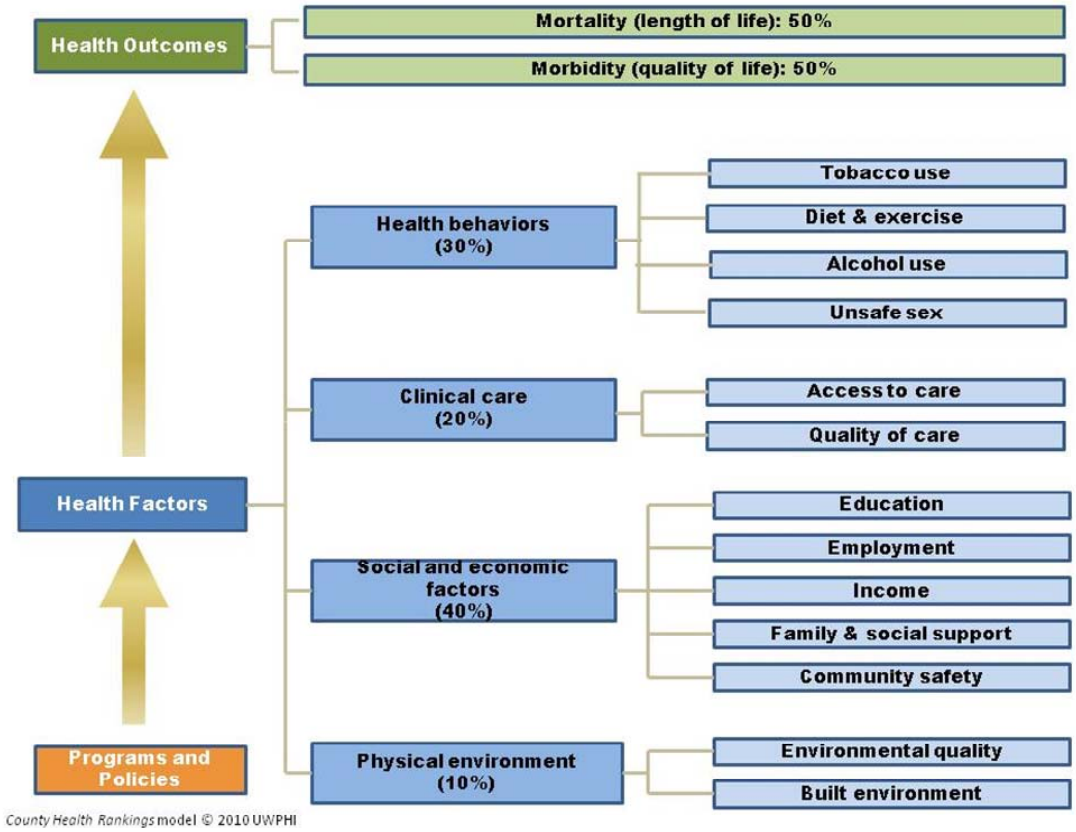
vitality. It was envisioned that such a composite would include healthy behaviors related to the high-impact areas of tobacco and alcohol use, diet, stress management, and exercise. As with the development of a clinical preventive services composite, a parallel process would need to be undertaken for stakeholder engagement and buy-in, and to determine how the evidence would inform composite development and maintenance.

COMMUNITY INDEX OF HEALTH

Improving the health of American communities is a major goal of the NPP Priority area of Population Health. To do so, NPP identified the need for an "index of health" by which this goal would be assessed – an index that would include metrics for the key factors known to have the largest influence on health (e.g., health behaviors and social determinants) as well as clinical indictors traditionally used by the healthcare delivery system. Coinciding with the first day of this workshop, the release of the first annual 50-state County Health Rankings developed through the Mobilizing Action Toward Community Health (MATCH) program offers a step toward attaining this goal while filling a critical measure gap area.[9]

At the workshop, Dr. David Kindig, MD, PhD, principal investigator for the MATCH program provided an overview of the multifaceted model that serves as the foundation for the data elements collected around health outcomes, health behaviors, clinical care, social and economic factors, and physical environment that are rolled into a summary score and then ranked at the county level. Diagram 1 presents a snapshot of the components of this model.

Diagram 1
County Health Rankings: Factors Considered



Workshop participants agreed that this model provides a promising starting point for considering these types of composite indices and how they might be used by communities to assess, monitor, and improve overall health status. A key takeaway message from the dialogue emphasized implementation issues, and questioned how best to make these measures more actionable by stakeholders in the community and beyond. A critical next step put forth was to identify and link evidence-based best practices and interventions to these indicators at the federal, state, and county level. Additionally, this would offer an opportunity to explore what enables certain counties to make gains, and the mechanisms and context that lead to improved outcomes. The NPP Population Health workgroup and other constituents at the workshop committed to continue working with Dr. Kindig and his colleagues in the evolution of this metric and completing the cycle from measurement to action.

IV. Implications for Health Information Technology

Many of the action steps recommended by workshop participants will require the collection and aggregation of data to facilitate quality improvement, to encourage and enable value-based purchasing, and to serve as an accountability mechanism for consumers. Participants explored the implications of HIT, how these tools could facilitate the integration of data sources across public health and the healthcare delivery system, and how they align with current meaningful use criteria as required under the American Recovery and Reinvestment Act of 2009.

Integrating Data Sources

A resounding theme from the HIT discussion is the critical need to capture and aggregate multiple types of data (e.g., clinical, administrative, public health, claims) from various sources (e.g., hospitals, health plans, providers, employers and their vendors) in order to obtain a complete "picture" of the patient that includes prominent risk factors such as social determinants of health. For example, the state of North Carolina has mandated community health assessments that integrate public health data and healthcare delivery system data, and by bridging these systems is better informed and better equipped to address the overall health of the population.[10]

Of particular interest was a challenge to HIT vendors to incorporate data from public sources, such as from the Women, Infants, and Children Program (WIC) or the Ryan White HIV/AIDS Program, in addition to providing clinical information at the point of care. The use of personal health records (PHRs) was also discussed as a complementary data collection tool. Specifically, PHRs could capture specific patient/demographic information and thus enable collection of data related to social determinants. This data could ultimately supplement data collected today through electronic health records (EHRs), which typically do not capture or track this type of information.

There was also considerable discussion about the leveraging of health plan health risk assessment (HRA) data and harmonizing it with public health data (e.g., Behavioral Risk Factor Surveillance System) and clinical data to develop a comprehensive patient "assessment." Publicly and privately collected survey data coupled with clinically enriched data offer opportunities to link, for example, an individual's self-report on smoking status to whether or not an appropriate intervention was taken, such as receiving smoking cessation counseling from a provider. Standardization of data elements around risk factors across

sectors is also needed, as currently this information is not collected in a uniform way that would easily allow for aggregation.

Alignment with Meaningful Use Agenda

Building on the momentum surrounding HIT policy and EHR adoption, workshop participants specifically focused on HIT, population health, and meaningful use policy. In particular, the discussion centered on current "meaningful use" criteria for EHRs, which are defined by the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology, and which set the bar for EHR use for eligible professionals, hospitals, and critical access hospitals. Entities that adopt certified EHR technology and meet meaningful use criteria will be eligible to receive incentive payments through CMS.[11]

Workshop participants raised concerns that the meaningful use criteria, as currently defined in regulation, are more oriented toward the healthcare delivery system than the public health system or needs of population health. However, with NPP serving as the framework for meaningful use, a more comprehensive view that includes public health can be fostered by targeting clinical preventive eservices, healthy lifestyle behaviors, and a community index of health. An infrastructure that enables the integration of data from clinical and community-based services will be an essential component to this more inclusive approach.

V. THE PATH FORWARD

The key drivers and associated actions, measure gap areas, and implications for HIT presented in this report are a starting point by which all stakeholder groups should evaluate their potential to contribute to progress on NPP's Population Health Goals. The path forward includes further drilling-down on the specific steps that need to be taken and by whom and identifying those who are already leading by example—both individually and in partnership—to realize the action plan laid out.

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[1] National Priorities Partnership, *National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare,* Washington, DC: National Quality Forum; 2008.
[2] Ibid.
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[6] Massachusetts Office of Health and Human Services, P*ress Release: Patrick Administration Announces Positive Results from MassHealth Smoking Cessation Benefit*, November 18, 2009.
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[9] Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, *Mobilizing Action Toward Community Health (MATCH).* Available at www.countyhealthrankings.org/ and uwphi.pophealth.wisc.edu/pha/match.htm.
[10] North Carolina State Center for Health Statistics, *North Carolina Community Health Assessment Initiative (NC-CHAI)*. Available at www.schs.state.nc.us/SCHS/about/chai.html. Last accessed March 2010.
[11] Centers for Medicare & Medicaid Services, *CMS Fact Sheet: Medicare Incentive Program*. Available at www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3563. Last accessed March 2010.

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INVITED PARTICIPANTS

Peter Briss (Co-Chair)
Centers for Disease Control and Prevention, Atlanta GA

George Isham (Co-Chair)
HealthPartners, Bloomington, MN

Janet Allan
University of Maryland School of Nursing, Baltimore, MD

Gail Amundson
Caterpillar Inc., Peoria, IL

Andrew Baskin
Aetna, Blue Bell, PA

Georges Benjamin
American Public Health Association, Washington, DC

Michael Bilton
Association for Community Health Improvement, Chicago, IL

William Bruning
Mid-America Coalition on Health Care, Kansas City, MO

Ahmed Calvo
Department of Health and Human Services, Rockville, MD

Randall Cebul
Better Health Greater Cleveland, Cleveland, OH

Carolyn Clancy
Agency for Healthcare Research and Quality, Rockville, MD

Laura Cranston
Pharmacy Quality Alliance, Inc., Fairfax Station, VA

Cliff Fullerton
Baylor Health Care System, Dallas, TX

Robert Gould
Partnership for Prevention, Washington, DC

NATIONAL PRIORITIES PARTNERSHIP
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Garth Graham
Department of Health and Human Services, Rockville, MD

Linda Harris
Department of Health and Human Services, Rockville, MD

Paul Hartlaub
Wheaton Franciscan Medical Group, Brown Deer, WI

Laura Hessburg
National Partnership for Women & Families, Washington, DC

Peggy Honore
Department of Health and Human Services, Washington, DC

Paul Jarris
ASTHO, Arlington, VA

David Kindig
University of Wisconsin Medical School, Madison, WI

Tom Kottke
HealthPartners, Bloomington, MN

Michael Lieberman
GE Healthcare, Hillsboro, OR

Michael Maciosek
HealthPartners Research Foundation, Minneapolis, MN

Rose Martinez
Institute of Medicine, Washington, DC

Suzanne Mercure
National Business Coalition on Health, Washington, DC

David Meyers
Agency for Healthcare Research and Quality, Rockville, MD

John Miller
Mid Atlantic Business Group on Health, Greenbelt, MD

Susan Milner
National Committee for Quality Assurance

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Charlotte Mullican
Agency for Healthcare Research and Quality, Rockville, MD

Rita Munley Gallagher
American Nurses Association, Silver Spring, MD

Eugene Nelson
Dartmouth Hitchcock Medical Center, Lebanon, NH

Tom Nolan
Institute for Healthcare Improvement, Naperville, IL

Todd Park
U.S. Department of Health and Human Services, Washington, DC

Stephen Persell
Feinberg School of Medicine, Chicago, IL

Alisa Ray
Certification Commission for Healthcare Information Technology, Chicago, IL

Patrick Remington
University of Wisconsin School of Medicine and Public Health, Madison, WI

Kyu Rhee
Health Resources and Services Administration, Rockville, MD

Chelsey Richards
Centers for Disease Control and Prevention, Atlanta, GA

Sarah Sampsel
WellPoint, Rio Rancho, NM

Kathleen Shoemaker
Eli Lilly and Company, Indianapolis, IN

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

Matt Stiefel
Kaiser Permanente, Oakland, CA

Barry Straube
Centers for Medicare & Medicaid Services, Washington, DC

Cynthia Tuttle
National Business Group on Health, Washington, DC

NATIONAL PRIORITIES PARTNERSHIP
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Andrew Webber
National Business Coalition on Health, Washington, DC

Gina Wei
National Institutes of Health, Bethesda, MD

Don Wright
U.S. Department of Health and Human Services, Washington, DC

Xingyou Zhang
Centers for Disease Control and Prevention, Atlanta, GA

PROJECT STAFF

Tom Valuck
Senior Vice President, Strategic Partnerships

Karen Adams
Vice President, National Priorities Partnership

Bonnie L. Zell
Senior Director, Population Health

Wendy Vernon
Senior Program Director, National Priorities Partnership

Jenissa Haidari
Program Director, National Priorities Partnership