NQF
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Quality Connections

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Population Health

Introduction

The ultimate goal of the U.S. healthcare delivery system is to improve *health*. However, our system does not devote sufficient energy or resources toward achieving this goal.

This is not to say that we don't spend a great deal of money on healthcare. We do, significantly more than any other nation.[1] Thanks to millions of committed and highly skilled healthcare workers and sophisticated medical technology, our system provides an expansive array of medical care services to individuals. The quality of these services is highly variable. In the decade since the Institute of Medicine (IOM) issued landmark reports identifying patient safety and quality deficiencies in the U.S. healthcare system,[2,3] numerous federal, regional, and local quality improvement initiatives have commenced throughout the country. Many of these have improved care, usually by focusing on points at which care is delivered (e.g., acute care hospitals, nursing homes).

However, people do not live in the U.S. healthcare delivery system. Improvements in the personal healthcare system alone will not be enough to achieve a healthy population.

Except under certain circumstances, individuals intersect with healthcare for limited and defined periods. People enter the system, receive a treatment (or a prescription for a treatment), and leave, often going back into a world that does little to encourage health. Even the large numbers of Americans who suffer from chronic conditions often receive care that is poorly coordinated[4] and not integrated with their lives outside of the healthcare delivery system interventions.

Reaching people where they live is a goal that by and large eludes healthcare providers. As a nation, we are less healthy as a result. Ours is a system that directs enormous resources toward healthcare, yet neglects health—because it shortchanges those contextual factors (e.g., environmental, behavioral, social) that can have the greatest impact on improving health. The American healthcare delivery system often operates as if in a vacuum, focusing only on the disease in front of it rather than the factors that contribute to Americans' health or lack thereof, failing to realize that health, not simply lack of acute illness, is its ultimate goal.

This is something that the U.S. public health system understands intuitively. Public health—the practice of preventing disease and promoting good health within groups of people, from small communities to entire countries[5]—has for decades advanced the cause of health, often with scarce financial resources. Traditionally, public health is described as the function of governmental agencies such as health departments to prevent disease outbreaks and advance health; its interventions (e.g., immunizations, sanitation, education,) have significantly lengthened Americans' life expectancy.

But a far more robust public health system is needed to address our country's critical health needs. Obesity (adults and children), diabetes, asthma, tobacco-related illnesses, and other chronic conditions place great strain on the health and wellbeing of millions of Americans. People from "at-risk" communities (e.g., racial and ethnic minorities, low-income families, and low-education families) suffer from these conditions at disproportionately high rates.[6] Too often, these conditions—which are largely behavioral, social, economic, or environmental in nature—lead to premature death.[7]

It is tempting to blame the healthcare system or even individual healthcare providers for these issues, but such blame would be misplaced. Healthcare is just one of the five domains that influences health—the other four being genetics, social circumstances, environmental exposures, and behavioral patterns.[8,9,10] It is estimated that at least two-fifths of deaths in the United States can be attributed to behavioral factors, with another one-fifth of deaths attributable to social circumstances and physical environmental factors.[11,12]

To correct this, there is emerging effort to influence the health of individuals and populations where they spend their time—at home, at work, at school, or in their communities. Recognizing that wide chasms exist between the health of some communities and that of others, interest is growing in focusing national health improvement efforts with a *population health* approach. Population health seeks to foster health and wellness and to prevent (rather than simply treat) injury, illness, and disability. It does so by considering the context and circumstances of individuals, both as individuals and as members of a group with similar demographics or exposures, to improve outcomes. Taking a population health approach emphasizes that healthcare is only one factor that influences health and that other factors need to be addressed if we are to improve the health of the nation.

The U.S. public health community has long sought to improve the health of populations; however, there is growing recognition that a population health focus requires alignment of goals and partnerships among multiple stakeholders, including healthcare providers. The healthcare delivery system can play multiple pivotal roles. Clinical and contextual data can be collected and analyzed, with resources directed accordingly; healthcare providers can communicate with and support individual patients and populations of patients. Healthcare providers must work with public health, federal and local governments, and other community stakeholders (e.g., employers, schools, organized labor, and consumer organizations) to advance population health.

Population Health: Definitions, Challenges, And Opportunities

Health happens at the individual level, with one person making decisions every day. These decisions are influenced by the cultural, environmental, and social contexts of how he or she lives—a basic fact that the U.S. healthcare delivery system has yet to embrace. Individuals are members of groups, communities, and ultimately populations. Population health addresses those contextual factors with the intention of addressing the health inequities to which they lead.

Several definitions of population health inform this field. The World Health Organization defines population health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[13] The Institute of Medicine offers a three-point definition: a "state of well-being and capacity to function in the face of changing circumstances;" a "positive concept emphasizing social and personal resources as well as physical capabilities; and the "shared responsibility of healthcare providers, governmental public health and a variety of actors in the community."[14] And, the University of Wisconsin School of Medicine and Public Health, Population Health Institute also offers a three-point definition: it terms population health a "body of scientific disciplines interested in the study of distribution and determinants of health and disease states in a population;" an "approach to health that seeks to step beyond the individual-level focus of traditional clinical and preventive medicine by addressing a broad range of factors that impact health on a population-level;" and a "focus on ways to reduce health inequities among population groups by exploring factors such as the environment, social structures, resource distribution, and other key determinants of health." [15]

"Health isn't just the quality of care one receives in the healthcare delivery system. Health is determined by where a person works, learns, eats, plays, shops, and sleeps," says George Isham, MD, MS, medical director and chief health officer, HealthPartners, Bloomington, MN, and co-chair of the National Priorities Partnership Workgroup on Population Health. "Health is influenced by a person's level of education, income, employment, preferences, and multiple other factors. Population health is built around the belief that the health of individuals, as members of groups, can be measured and improved. To plan care accordingly, the healthcare delivery system needs to take this information into account."

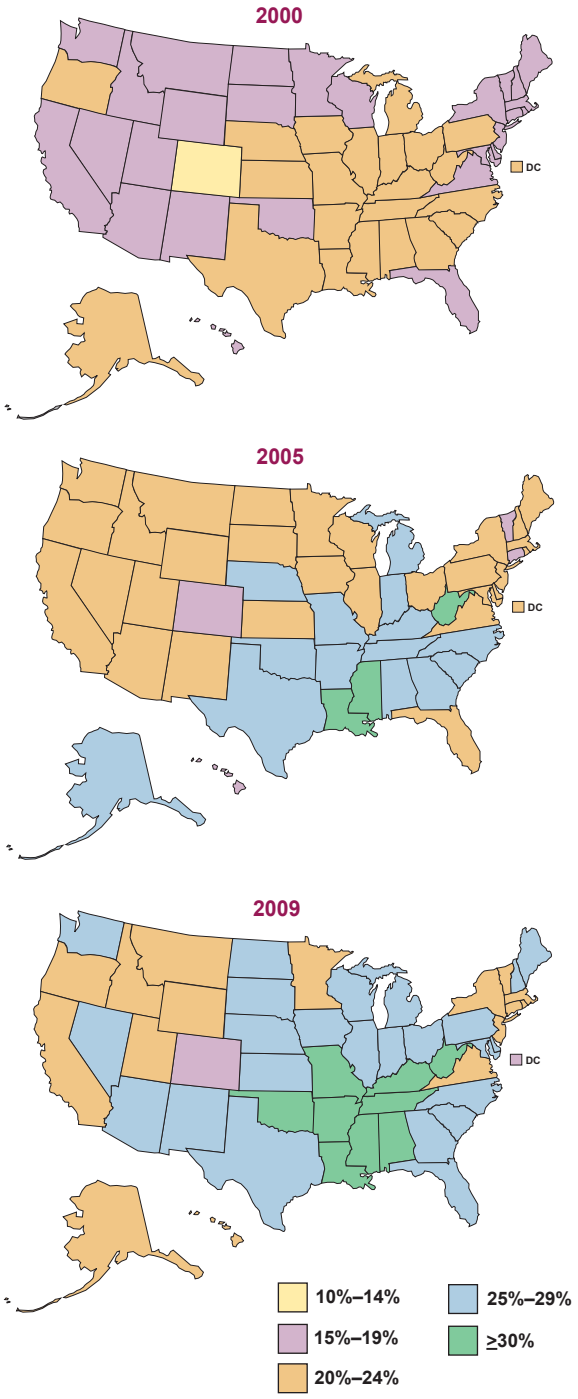
The population groups defined in population health often are residents of geographic regions but also can be other groups (e.g., specific racial or ethnic groups, disabled people, prison inmates, or schoolchildren). Thus, population health demands the rigorous measurement of health outcomes, both individual and in the aggregate by groups, and analysis of inequities to understand and compare groups' health statuses.

Analysis of health issues from a population health perspective should lead to population-level interventions, the clearest example of which is the nation's extended anti-smoking campaign—although this effort is far from finished. While tobacco use remains the leading preventable cause of disease and death in the United States,[16] the rate of cigarette smoking in the United States has declined by half since 1965, a year after publication of the U.S. Surgeon General's initial Report on Smoking and Health.[17] This is due in part to a sustained series of anti-smoking initiatives at the federal, state, and local levels, including consumer outreach, clinician education, prohibition of smoking in public places, the ban on tobacco advertisements targeting children, and the Tobacco Master Settlement Agreement of 1998.

Clearly, the national anti-smoking campaign was in part a healthcare initiative, as millions of patients received counseling from their healthcare providers to quit, were prescribed medications to quit, or used quit-smoking hotlines or other means of reaching individuals. But this was also a population health intervention, because it went beyond healthcare; while tobacco was the target, the means to get to it was America's culture of smoking. Population-level activities included prohibiting smoking in the workplace and restaurants, restricting the sale of tobacco to minors, restricting advertising, and increasing taxes on cigarettes. The campaign has benefitted from partnerships among multiple stakeholders and aligned goals.

Thus, the successful (yet still incomplete) battle against tobacco use can serve as a nationwide model for other important

Self-reported prevalence of obesity* among adults: Behavioral Risk Factor Surveillance System, United States, 2000, 2005, and 2009



*The figure above compares the prevalence of state-specific obesity in 2009 with 2005 and 2000. A total of 33 states had obesity prevalences >25 percent in 2009, and nine of those states had prevalences ≥30 percent. In contrast, 28 states had prevalences <20 percent in 2000, and no state had a prevalence of ≥30 percent.

Source: Sherry B, Blanck HM, Galuska DA, et al., Vital signs: state-specific obesity prevalence among adults—United States, 2009, *MMWR*, 2010;59(30):951-955.

population health interventions. Today, there is great need for many targeted population-level interventions. Consider the example of obesity. Obesity in the United States has grown increasingly prevalent; in 2009, at least 30 percent of adults were obese in nine states, compared with no states in 2000.[18] (See graphic at left.)

Obesity frustrates healthcare providers, in part because of the health issues to which it leads and in part because they feel helpless to prevent or ameliorate it. Both the growth of obesity overall in the past decade and its disproportionate impact on certain populations indicate that healthcare providers' interventions have failed. But obesity isn't just a healthcare problem. We will never mitigate obesity until we intercede on its underlying causes, which include poor eating habits, lack of access to fresh fruits and vegetables in certain neighborhoods, and lack of time or a safe place to exercise. Inattention to such information, and failure to collect, consider, and report relevant data on these factors, can lead to what experts call "contextual error," which can be as severe as and can lead to actual medical error.[19] These causes indicate the need for community-level, multistakeholder population health interventions.

Thus, population health, assessing functional status, risk status, and disease status of individuals as members of groups, is a healthcare concern, but not solely such. "Population health combines healthcare for individuals and health for groups," says Janet M. Corrigan, PhD, MBA, president and CEO of National Quality Forum (NQF). "Oftentimes, we know what to do for the individual, but social or societal barriers inhibit our ability to do it. Population health stands at the intersection of prevention, public health, and healthcare, and thus at the intersection of sectors that influence health, giving context to this predicament."

The case for targeted population health interventions also is made by analysis of health disparities. Study of these disparities, measured and reported annually by the federal government,[20] reveals that inequities in the provision of healthcare and overall health status exist for certain populations, including racial and ethnic minorities and the elderly, while geographic disparities remain pervasive.

For instance, in 2007, 68 percent of Hispanic and 56 percent of African American adults over the age of 65 were identified as never having received a pneumococcal vaccination, compared with only 38 percent of white adults in the same age group.[21] African Americans are more likely to develop and die from cancer than any other group, and death rates are 17 to 37 percent higher than those of whites.[22,23] A closer look at obesity statistics reveals that obesity varies substantially by selected characteristics, including race,

education, and geography; among women with less than a high school degree, 36.4 percent are obese, almost double that of college educated women (18.6 percent). Among states, the prevalence of adult obesity ranged from 18.6 percent in Colorado to 34.4 percent in Mississippi.[24]

Population Health: Healthcare Delivery System Roles and Relationships

Population-level interventions can succeed. When they do, it is usually because multiple stakeholders—including public health, healthcare providers, and community entities such as schools and employers—create partnerships and align goals, performance measures, initiatives, and incentives.

The extended anti-tobacco campaign is our clearest example of a successful population health intervention. Tobacco taxes were raised, smoking was prohibited in schools and workplaces, and limits were placed on advertising. Importantly, though, the healthcare delivery system participated, as hospitals set up hotlines and physicians counseled their patients to quit. These individual-level and population-level strategies reinforced each other, to great effect.

"Work to close gaps revealed by healthcare disparities can be accomplished only through vigorous, sustained, and well-integrated initiatives by both the public health and healthcare sectors," says Capt. Peter A. Briss, MD, MPH, medical director, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, and co-chair of the National Priorities Partnership Workgroup on Population Health. "These activities include outreach and community support through public health agencies, services and follow-up by healthcare providers, and work by both to identify and commit the necessary resources."

The anti-smoking model can be applied to childhood obesity, which most health policy analysts consider an epidemic. Typical healthcare interventions include weight and height measurement, calculation of body mass index, and counseling about diet and exercise. Population health strategies take into account outside influences, attempting to address whether the child's family can afford to buy nutritious food and knows how to prepare it, whether grocery stores near his or her home actually sell nutritious ingredients, and whether the neighborhood is safe for exercise.

First Lady Michelle Obama has made childhood obesity a cornerstone issue and has set a national goal of reducing it with her Let'sMove! campaign, which promotes making healthy choices, improving food quality in schools, increasing access to healthy, affordable food, and exercise.[25] Among other stakeholders, the Let'sMove! initiative involves school nutritionists and leaders, school food suppliers, lawmakers, chefs, and others.

Not all population health initiatives need be so broad. A healthcare provider can lead an initiative or merely be a participant. Consider the following case studies:

- In Dallas, TX, Baylor Health Care System has created a new Diabetes Health and Wellness Institute in a medically underserved community in South Dallas. Staffed by physicians, nurses, care coordinators, and diabetes education specialists, the institute offers simple approaches to combating the disease, such as a weekly farmers market at discounted prices, cooking classes, exercise classes, and wellness classes. The Institute is the result of a unique public/private joint effort between Baylor and the city government, which helped Baylor by allowing the system to invest $15 million in renovating and transforming an already-established city recreation center.[26]

- Catholic Healthcare West (CHW) has developed an approach to establishing system community benefit initiatives informed by evidence. In 2002 CHW, in partnership with Thomson Reuters (formerly Solucient) developed a Community Need Index (CNI). The CNI numerically scores zip codes based on the socio-economic barriers, including income, education, insurance, culture/language, and housing, that evidence has shown put residents at higher risk of both needing and utilizing healthcare services. The research has demonstrated that admission rates in high-need areas are twice that of low-need areas. This evidence led to the development of quantitative data sets for each hospital based on the utilization of their respective communities for ambulatory care-sensitive conditions.

  CHW then established a system metric goal to address the unmet needs identified in the CNI and confirmed by hospital in-/outpatient utilization with evidence-based approaches. Focusing on ambulatory care-sensitive conditions (such as asthma, congestive heart failure, or diabetes) and geographic areas with known unmet health-related needs, the facilities applied approaches over a three-year period that resulted in a reduction of admissions or readmissions for these condi-

tions by an average of 86 percent among participants in the intervention. In addition, CHW's corporate investment program helped to bolster community-based organizations serving the safety net with low-interest loans or lines of credit, helping to ensure or improve access to primary care.

- HealthPartners established a five-year strategic plan that included an initial set of long-term strategic health goals. Through this plan, mammograms and immunizations were increased, while the incidence of chronic disease and diabetes complications were decreased. Five years later, goals were included specifically to address lowering costs and improving care.

  During successive five-year strategic plan updates, HealthPartners has built on the foundation of its initiatives by developing stronger measures, engaging all operating units into the planning process, incorporating the IHI Triple Aim. For 2014, it has added a number of guiding principles such as leveraging relationships with key industry experts, community leaders, and others to provide input into their agenda, and aligning with key community initiatives. Additionally, the 2014 strategic plan goals have explicitly incorporated a "social determinants of health model" with the help of David Kindig, MD, PhD, and his team at the University of Wisconsin. This has broadened their goals to improve the overall health of the communities they serve. This model has focused their efforts on engaging their communities to find out what is important, what is needed and what will work. It was determined that the greatest impact would be to develop programs and services to support better family cohesion and address mental health needs by addressing violence, injury, chronic health issues, and, in turn, mortality.

Beyond programmatic interventions, the healthcare provider community has a significant role to play in improving the health of the population it serves. Providers can start by bringing population health *assessments* into healthcare. To the extent possible, providers should query their rich clinical and administrative databases to gain a fuller understanding of their populations; use publicly available data to understand community context (e.g., geographic information system mapping); and integrate their own data with public health data. For many providers in small practice settings, accessing this kind of information will require building partnerships with health plans, hospitals, and health systems.

This can be followed with bringing population health *strategies* into healthcare. These can include targeted outreach for screening and follow-up care after visits by certain population segments; the use of community-level resources targeted to specific populations; education (e.g., newsletters) to certain populations with population-specific health information; and the formation of partnerships with other stakeholders in the community. These strategies can produce population health initiatives that can demonstrate positive health results.

While some population health initiatives can take years to create and implement, there are things that the healthcare delivery system can do in the immediate term. These include:

- considering context as a performance measure or indicator for assessing and planning care for individuals and populations within the healthcare delivery system;
- instituting regional community health assessments across healthcare systems and coordinating those assessments with public health departments;
- investing community benefit dollars to form a collaboration with other healthcare providers in the community and with non-healthcare provider stakeholders (e.g., public health, schools, employers);
- developing, enhancing, and taking leadership roles in community health coalitions with stakeholders, including schools and employers;
- setting an example as an employer by encouraging exercise and healthy eating and ensuring that health benefits cover prevention; and
- aligning assessment, measures, and initiatives from a regional perspective to improve population health outcomes and the experience of the individuals in the community and to maximize value across the local health system.

Overcoming Barriers to Population Health

These examples demonstrate that targeted population health interventions can work. However, significant barriers exist to their large-scale implementation.

Population health initiatives often fail to commence because strategic priorities and specific roles of diverse

stakeholders are not clearly articulated. "Population health starts with the across-the-board recognition that the ultimate goal of healthcare and governmental public health is better health for individuals and populations within their communities," says Bonnie L. Zell, MD, MPH, senior director for population health for NQF. "This requires building relationships and trusted partnerships that include healthcare, public health, and other key community stakeholders whose policies influence health, with a clear understanding of how to best utilize the unique leverage and resources of each sector and develop measures and incentives for shared accountability for outcomes."

A second, related barrier is funding. While high-profile issues like childhood obesity enjoy inherent attention and some small-scale interventions demonstrate proof of concept, current healthcare funding mechanisms do not support large-scale public investments. Notably, it took more than 30 years from the time the U.S. Surgeon General issued warnings about the use of tobacco until anti-smoking initiatives became well funded.

This funding conundrum has led to calls for a "pay-for-population" mechanism in which health providers are reimbursed not only for the number of procedures they perform (i.e., pay for procedure) or the quality of the procedures they perform (i.e., pay for performance), but on the overall health outcomes of the communities they serve.[27] Instituting a pay-for-population funding scheme faces many challenges, such as the development of population health measures, coordination across sectors, and unintended consequences, but, as population health expert David A. Kindig, MD, notes in the *Journal of the American Medical Association*, "Full potential for improving population health cannot be achieved without first developing appropriate financial mechanisms… Voluntary efforts are not powerful enough to achieve this on a soft money basis." [28]

Next Steps: Population Health as a National Priority and NQF's Role

In 2008, the National Priorities Partnership (NPP)—a diverse group of national organizations representing those who receive, pay for, deliver, and evaluate healthcare—released an action agenda to transform healthcare by better investing resources to fundamentally improve patient care and outcomes. The NQF-convened Partnership selected population health as one of six "National Priorities" for national action in order to eliminate waste, harm, and disparities and to create and expand world-class, patient-centered, affordable healthcare.[29] The Priorities Partners declared a vision of "communities that foster health and wellness as well as national, state, and local systems of care fully invested in the prevention of disease, injury, and disability—reliable, effective, and proactive in helping all people reduce the risk and burden of disease."[30]

"The Priorities Partners' selection of population health as a national priority was a visionary and bold act because many regard population health as outside the direct purview of the healthcare system," says Margaret E. O'Kane, president of the National Committee for Quality Assurance and co-chair of the National Priorities Partnership. "This was a clear statement from the healthcare community that we need to pay attention to health, even when it occurs outside the walls of our institutions."

NATIONAL PRIORITIES PARTNERSHIP GOALS FOR POPULATION HEALTH

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

Source: National Priorities Partnership, *National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare*, Washington, DC: NQF; 2008.

As follow-up to its initial report, NPP established workgroups to provide guidance for the development of comprehensive action plans to drive change. Its Population Health workgroup convened a meeting early in 2010 to develop a comprehensive action plan. The workgroup focused on "drivers" of change—payment systems, public reporting, performance measurement, systems capacity, education and certification, and research and knowledge dissemination[31]—and identified which drivers and associated actions had the maximum potential to "move the needle" toward desired outcomes.[32] The workgroup identified two actions in the area of consumer engagement, five in system capacity, two in payment, and three in performance measurement to make up the comprehensive action plan. (See table on page 7.)

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 conseling).	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

The Patient Protection and Affordable Care Act[33] (ACA) provides an opportunity to build on the work of NPP and to amplify its impact. ACA calls for the creation of a National Quality Strategy, the initial version of which the Department of Health and Human Services (DHHS) is to submit to Congress in January 2011. The Affordable Care Act specifically legislates that the National Quality Strategy should address population health.

The Affordable Care Act also implicitly endorses population health by establishing the National Prevention, Health Promotion, and Public Health Council, which is composed of the heads of executive departments or agencies from across HHS and related agencies to "provide coordination and leadership at the Federal level with respect to prevention, wellness, and health promotion practices, the public health system, and integrative health care in the United States." The Council will submit to Congress by March 23, 2011, a strategy "that incorporates the most effective and achievable means of improving the health status of Americans and reducing the incidence of preventable illness and disability;" this includes prioritizing health issues, setting goals and objectives, and establishing measureable actions and timelines to address priority areas.

In addition to the Affordable Care Act, the federal government is pursuing multiple other initiatives that have a population health implication. These include Healthy People 2020,[34] a set of 10-year national objectives for promoting health and preventing disease to meet a broad range of health needs, encourage collaborations across sectors, guide individuals toward making informed health decisions, and measure the impact of prevention activities.

Conclusion

Health, ultimately, is local and both individual and population-based in nature.

Population health demands that systems be built around individuals and populations within the context of their communities. This approach also provides an opportunity to enhance the relationship between a patient and his or her provider. Where healthcare usually asks, "How do I treat the patient who has just walked in the door with this particular problem at this time?" population health broadens the scope to include the questions, "What population circumstances or conditions exist that are the underlying causes of this disease or incidence of this disease in our community at this time, and what conditions do we need to address to keep other people like this patient from getting this disease?"

Much work remains to implement broad-scale population health initiatives, and measure their performance. Population health-focused initiatives will ultimately succeed when hospitals and other healthcare provider organizations reassert their community focus, integrate their own data into population health assessments, and integrate their work with public health to take advantage of the talents of both fields.

Population health is broader than a "healthcare problem." It is a series of societal issues that demands multistakeholder commitment to discover and implement solutions together, aligning assessments, measures, and interventions. Healthcare providers must work with other stakeholders (e.g., public health, governments, schools, employers) to target individual and group-based interventions that will improve outcomes for all.

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The National Quality Forum (NQF) operates under a three-part mission to improve the quality of American healthcare by:

- Building consensus on national priorities and goals for performance improvement and working in partnership to achieve them;
- Endorsing national consensus standards for measuring and publicly reporting on performance; and
- Promoting the attainment of national goals through education and outreach programs.

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