Vital Signs

An Initiative of the National Academy of Medicine

Reducing Burden | Sharpening Focus | Improving Performance

Vital Signs Core Metrics:

Learning from the California Demonstration Project

WEBINAR

JUNE 16, 2017 | 12:00-1:30 PM ET

#NAMVitalSigns | @theNAMedicine

nam.edu/VitalSigns

WebEx Tech Support: 1-866-229-3239

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AGENDA

12:00 PM |	**Welcome & Introductions: Population Health Vital Signs**
	Michael McGinnis, National Academy of Medicine Claire Wang, National Academy of Medicine
12:15 PM |	**The California Vital Signs Demonstration Project**
	Steven Teutsch & Sue Grinnell, Public Health Institute Krista Hanni, Monterey County Health Department Genoveva Islas, Cultiva La Salud, Fresno, CA
12:45 PM |	**Reactions and Next Steps**
	Peter Long, Blue Shield California Foundation Elizabeth Mitchell, Network for Regional Healthcare Improvement Alina Baciu, NASEM, Roundtable on Population Health Improvement
1:05 |	**Audience Q&A**
1:30 |	**Adjourn**

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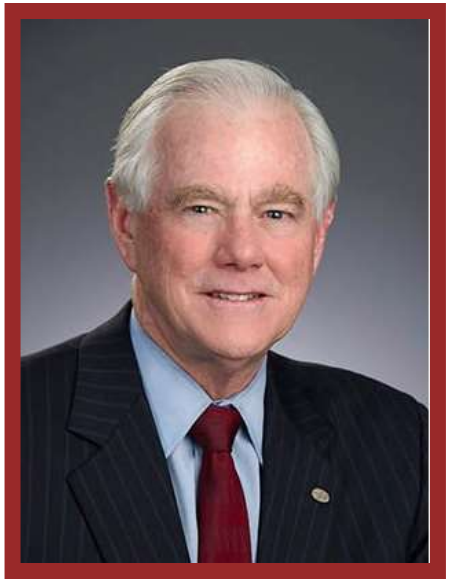

NAM Leadership Consortium

Vital Directions for Health and Health Care

J. Michael McGinnis, MD, MPP
Leonard D. Schaeffer Executive Director
National Academy of Medicine

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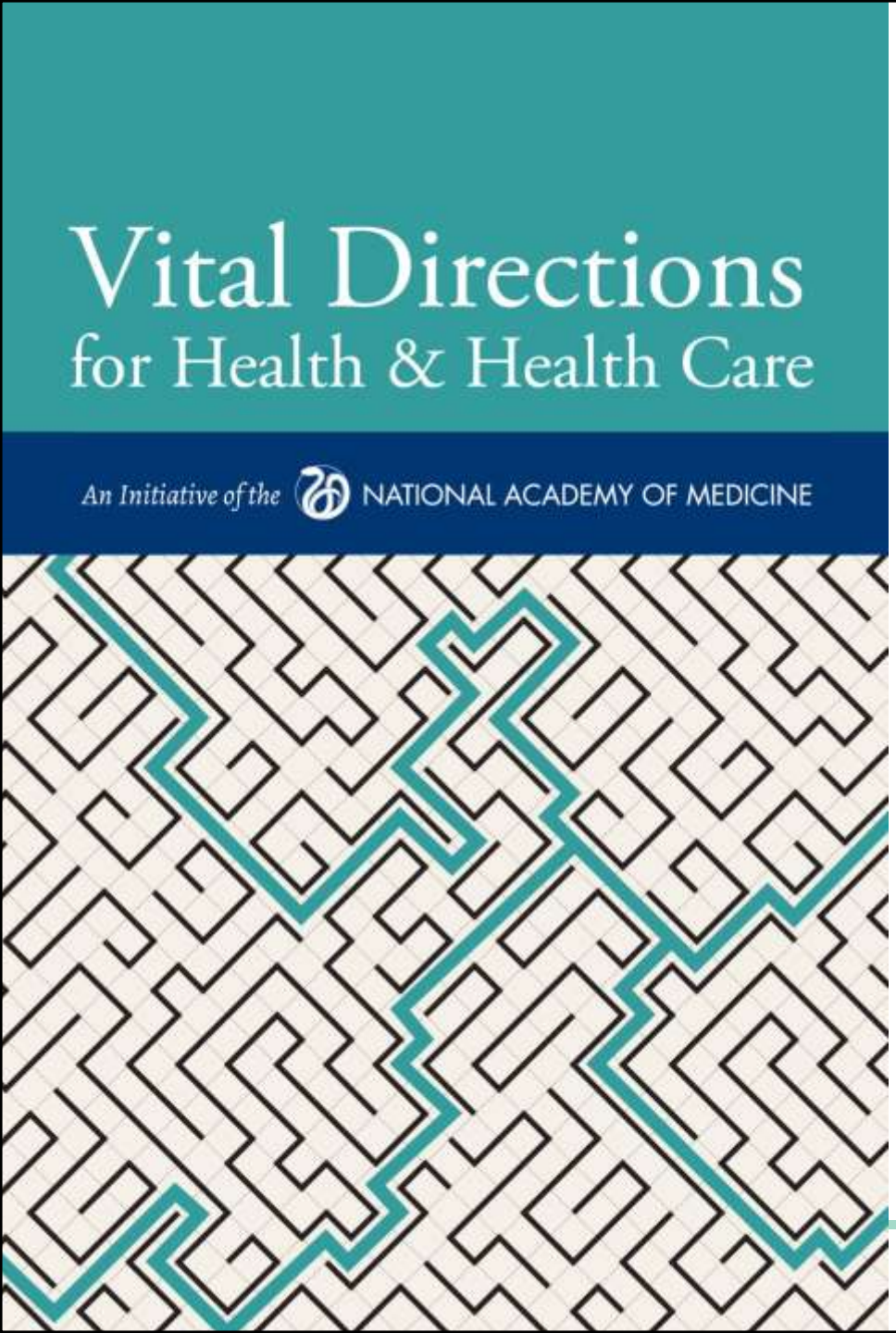

- 18 months of collective review, analysis, and deliberation
- Core goals:
  - Better health and well-being
  - High-value health care
  - Strong science and technology
- Commissioned 150+ experts to write 19 discussion papers

nam.edu/VitalDirections

JAMA | Special Communication

Vital Directions for Health and Health Care Priorities From a National Academy of Medicine Initiative

Victor J. Dzau, MD; Mark B. McClellan, MD, PhD; J. Michael McGinnis, MD, MPP; Sheila P. Burke, MPA, RN; Molly J. Coye, MD, MPH; Angela Diaz, MD, MPH; Thomas A. Daschle, BA; William H. Frist, MD; Martha Gaines, JD, LLM; Margaret A. Hamburg, MD; Jane E. Henney, MD; Shiriki Kumanyika, PhD, MPH; Michael O. Leavitt, BA; Ruth M. Parker, MD; Lewis G. Sandy, MD; Leonard D. Schaeffer, BA; Glenn D. Steele Jr, MD, PhD; Pamela Thompson, MS, RN; Elias Zerhouni, MD

Editorial

IMPORTANCE Recent discussion has focused on questions related to the repeal and replacement of portions of the Affordable Care Act (ACA). However, issues central to the future of health and health care in the United States transcend the ACA provisions receiving the greatest attention. Initiatives directed to certain strategic and infrastructure priorities are vital to achieve better health at lower cost.

OBJECTIVES To review the most salient health challenges and opportunities facing the United States, to identify practical and achievable priorities essential to health progress, and to present policy initiatives critical to the nation's health and fiscal integrity.

EVIDENCE REVIEW Qualitative synthesis of 19 National Academy of Medicine–commissioned white papers, with supplemental review and analysis of publicly available data and published research findings.

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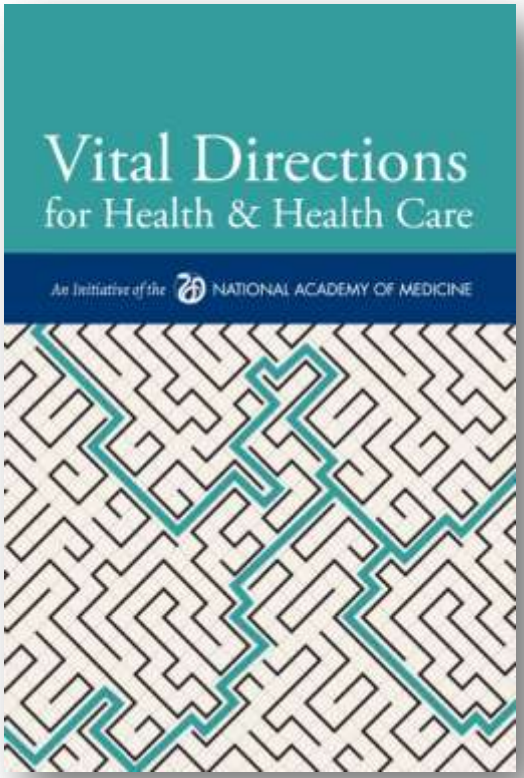
Eight Priorities

ACTION PRIORITIES

- Pay for value
- Empower people
- Activate communities
- Connect care

ESSENTIAL INFRASTRUCTURE NEEDS

- Measure what matters most
- Modernize skills
- Accelerate real-world evidence
- Advance science



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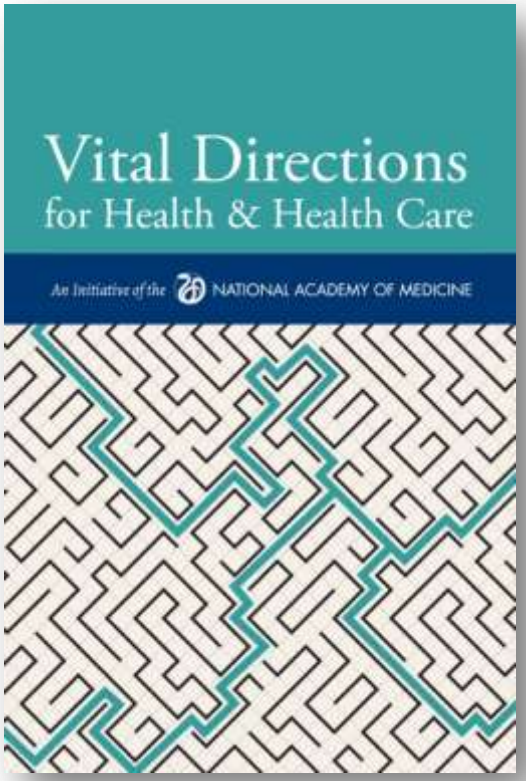

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Overview of the NAM Vital Signs Initiative

Y. Claire Wang, MD, ScD
Senior Program Advisor
National Academy of Medicine

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Study Committee

DAVID BLUMENTHAL (Chair), The Commonwealth Fund
JULIE BYNUM, The Dartmouth Institute
LORI COYNER, Oregon Health Authority
DIANA DOOLEY, California Health and Human Services
TIMOTHY FERRIS, Partners HealthCare
SHERRY GLIED, New York University
LARRY GREEN, University of Colorado at Denver
GEORGE ISHAM, HealthPartners
CRAIG JONES, Vermont Blueprint for Health
ROBERT KOCHER, Venrock
KEVIN LARSEN, Office of the National Coordinator for HIT
ELIZABETH McGLYNN, Kaiser Permanente
ELIZABETH MITCHELL, Network for Regional Health Improvement
SALLY OKUN, PatientsLikeMe
LYN PAGET, Health Policy Partners
KYU RHEE, IBM Corporation
DANA GELB SAFRAN, Blue Cross Blue Shield of Massachusetts
LEWIS SANDY, UnitedHealth Group
DAVID STEVENS, National Association of Community Health Centers
PAUL TANG, Palo Alto Medical Foundation
STEVEN TEUTSCH, Los Angeles County Department of Public Health

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Vital Signs: Core Metrics aims to:

Provide a streamlined set of measures as consistent benchmarks for health progress across the nation and improve system performance in the highest priority areas.

Rationale:

- Sharpening Focus
- Enhancing Consistency
- Reducing Burden

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Domain	Key Element	Core Measure Focus	Best Current Measure
Healthy people	Length of life	Life expectancy	Life expectancy at birth
	Quality of life	Wellbeing	Self-reported health
	Healthy behaviors	Overweight and obesity	Body mass index
		Addictive behavior	Addiction death rate
		Unintended pregnancy	Teen pregnancy rate
	Healthy social circumstances	Healthy communities	High school graduation rate
Care quality	Prevention	Preventive services	Childhood immunization rate
	Access to care	Care access	Unmet care need
	Safe care	Patient safety	Hospital acquired infection rate
	Appropriate treatment	Evidence-based care	Preventable hospitalization rate
	Person-centered care	Care match with patient goals	Patient-clinician communication satisfaction
Care cost	Affordability	Personal spending burden	High spending relative to income
	Sustainability	Population spending burden	Per capita expenditures on health care
Engaged people	Individual engagement	Individual engagement	Health literacy rate
	Community engagement	Community engagement	Social support

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Core Measure Set with Related Priority Measures

1. Life expectancy
Infant mortality
Maternal mortality
Violence and injury mortality

2. Well-being
Multiple chronic conditions
Depression

3. Overweight and obesity
Activity levels
Healthy eating patterns

4. Addictive behavior
Tobacco use
Drug dependence/illicit use
Alcohol dependence/ misuse

5. Unintended pregnancy
Contraceptive use

6. Healthy communities
Childhood poverty rate
Childhood asthma
Air quality index
Drinking water quality index

7. Preventive services
Influenza immunization
Colorectal cancer screening
Breast cancer screening

8. Care access
Usual source of care
Delay of needed care

9. Patient safety
Wrong-site surgery
Pressure ulcers
Medication reconciliation

10. Evidence-based care
Cardiovascular risk reduction
Hypertension control
Diabetes control composite
Heart attack therapy protocol
Stroke therapy protocol
Unnecessary care composite

11. Care match with patient goals
Patient experience
Shared decision making
End-of-life/advanced care planning

12. Personal spending burden
Health care–related bankruptcies

13. Population spending burden
Total cost of care
Health care spending growth

14. Individual engagement
Involvement in health initiatives

15. Community engagement
Availability of healthy food
Walkability
Community health benefit agenda

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Learn more at nam.edu/VitalSigns

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Implementation: Putting the Vital Signs to Use

Practical Applications

- Measure Progress
- Recognize Shortfalls
- Enhance Public Awareness
- Sharpen Focus
- Improve Accountability
- Foster Data Linkages
- Facilitate Informed Patient Choice

Ongoing Activities

- **Refine Core Metrics Towards V2.0**
- **Build Vital Signs User Resources**
- **Expand Network & Partnerships**
- **Cultivate Demonstration Projects**

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Pilot Implementation of the Vital Signs Metrics in Two Communities

Steve Teutsch
Public Health Institute

Sue Grinnell
Public Health Institute

Krista Hanni
Monterey County
Health Department

Genoveva Islas
Cultiva La Salud
Fresno County

Sponsor: blue of california foundation

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Project Goal

Demonstrate the feasibility and the usefulness of implementing the *Vital Signs: Core Metrics* in communities

Project Aims

- Provide greater specificity for each of the metrics
- Demonstrate that the Vital Signs can be implemented at the local level
- Build an attractive user interface
- Assess the usefulness of the Vital Signs at the local level, particularly in regard to improving population health
- Assess the feasibility of implementing the Vital Signs in other communities

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Two Sites Selected Based on:

1) Their current ability to collect and use metrics, including their engagement in related population health activities,
2) Representativeness of different types of community, e.g., urban or rural,
3) Geographic and ethnic diversity,
4) Pre-existing group or collaborative that has experience working together, and
5) Current engagement of PHI staff in the community

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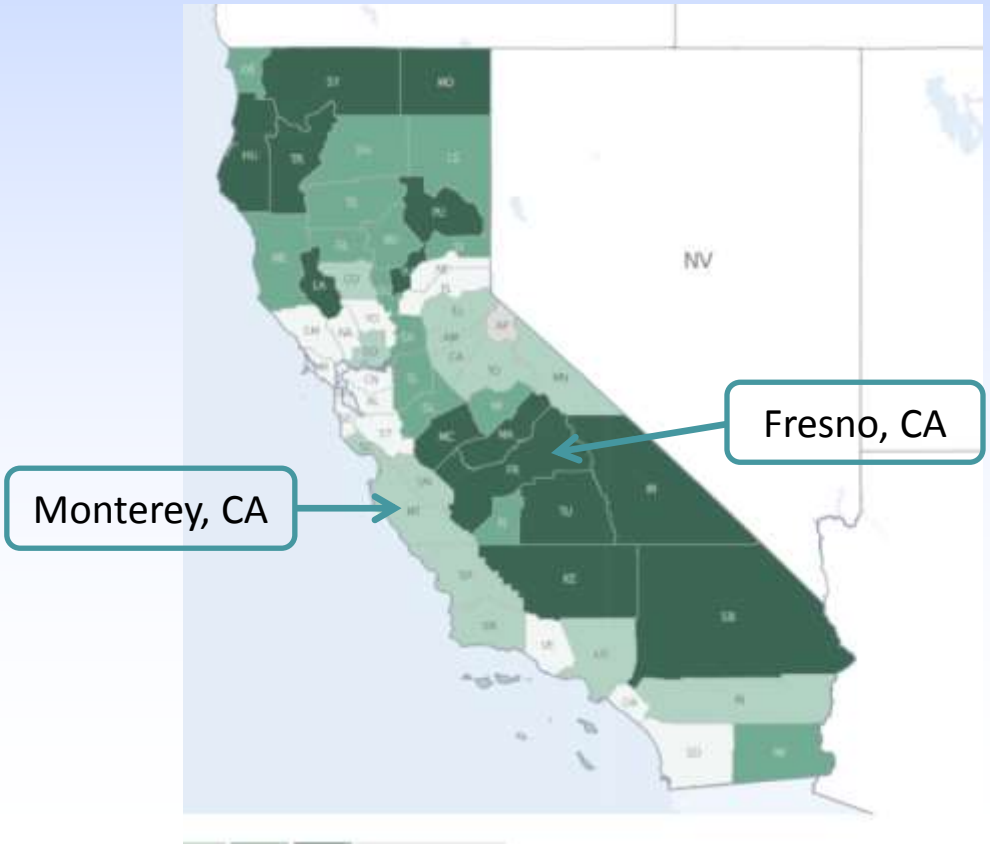
Identified Two California Communities

- Cultiva de Salud in Fresno
- Monterey County Health Department



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Implementation Process

- Conducted stakeholder interviews
- Orientation to the metrics and process intent
- 2 convenings at each site with a facilitator and graphic facilitator
- Each site received a small stipend

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Data Collection and Presentation

- Identified metrics that were available as similar to the Vital Signs as possible
- Supported the 2 sites in identifying and collecting data for one important measure outside of the core Vital Signs set
  - Safety - Monterey
  - Transportation - Fresno
- Working with each community, created LiveStories websites for the site to present the data, explain the findings, and discuss next steps

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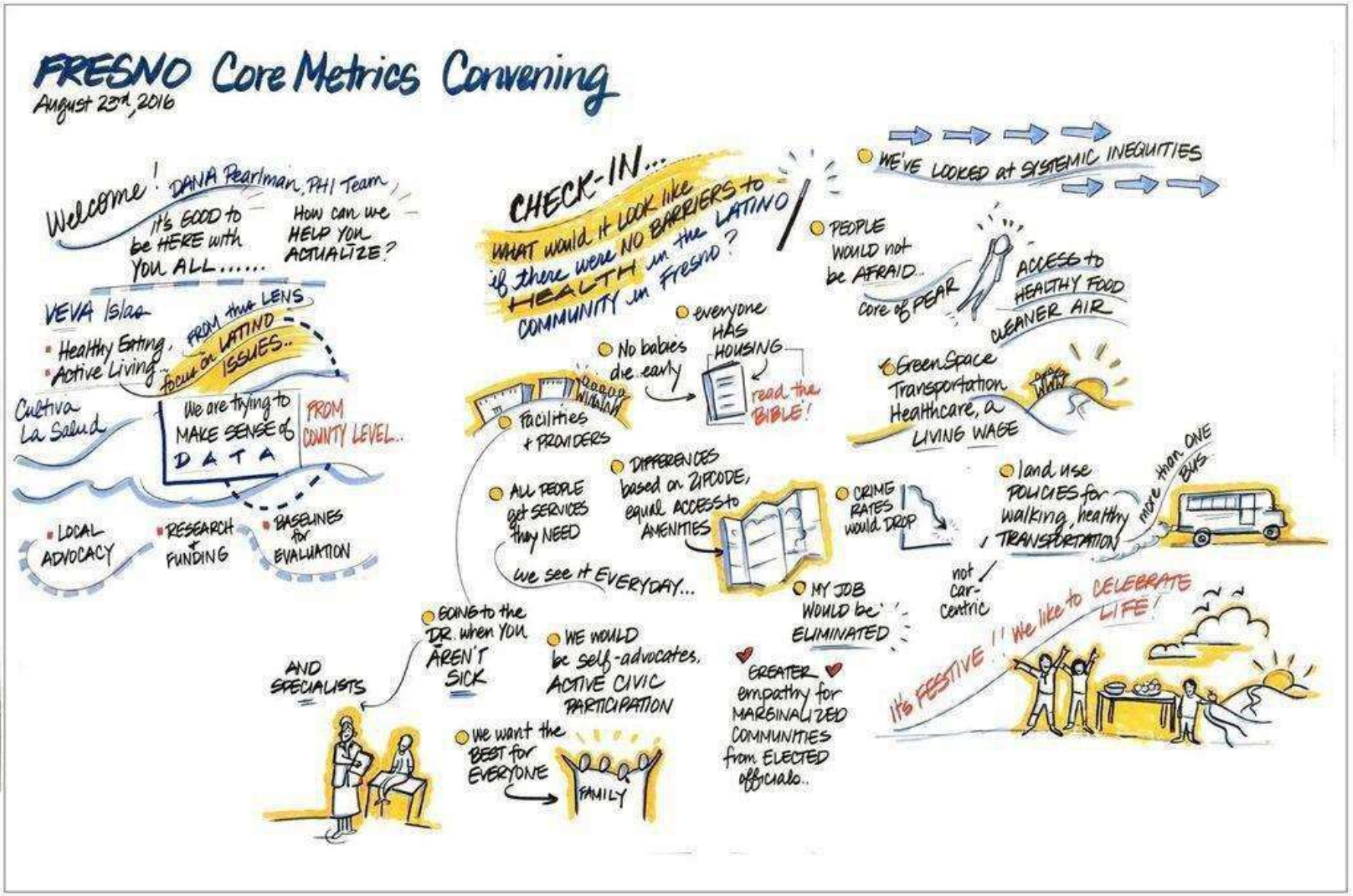
Data Compilation

- 14 of the 15 Core Metrics indicators available at the county level
  - 12 of the 14 were identical to those included in the National Academy's report.
  - For the 2 that were not identical, we used proxies:
    - Social support –voter turnout
    - Health literacy –English language literacy
  - Missing: High spending relative to income
- Indicators were collected for all California counties

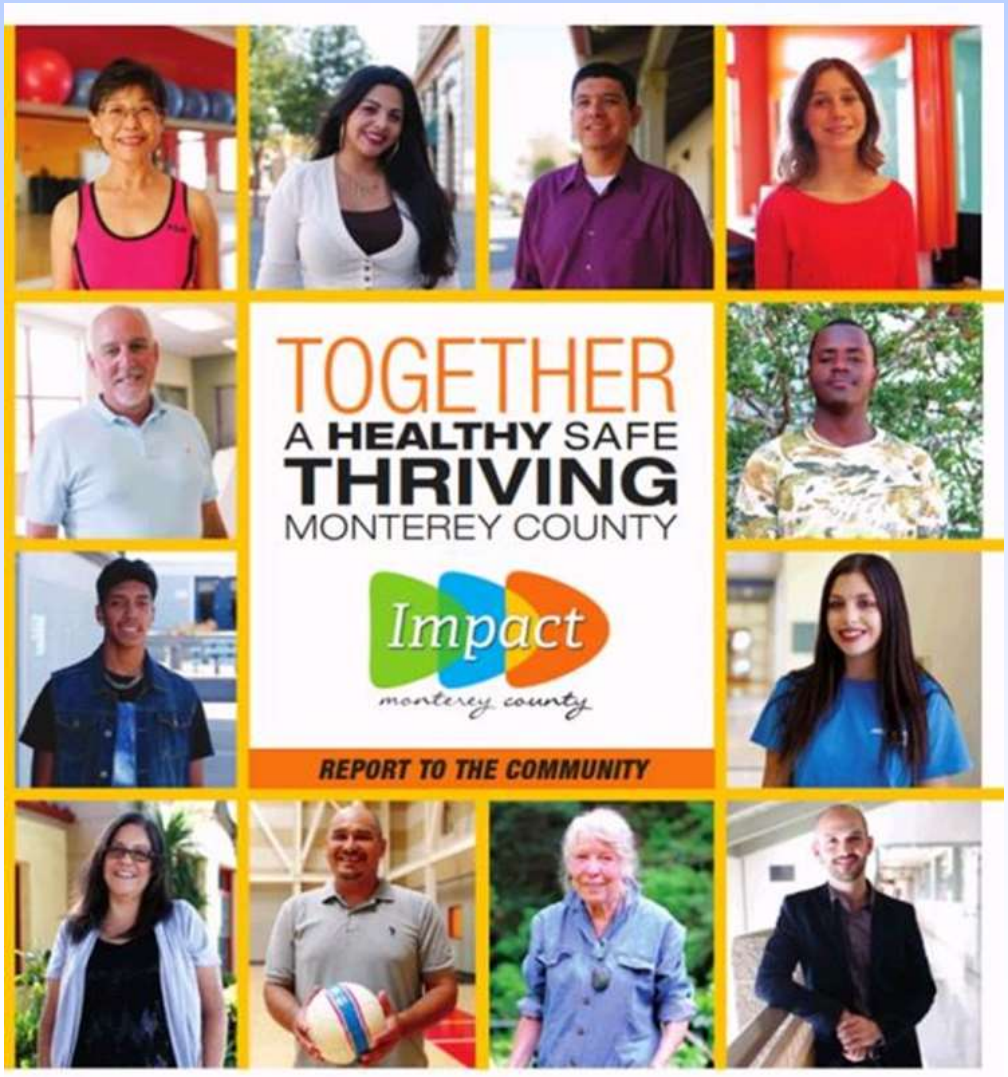

FRESNO Core Metrics Convening
August 23rd, 2016
Welcome! DANA Pearlman, PHI Team
It's GOOD to be HERE with YOU ALL.....
How can we HELP YOU ACTUALIZE?
VEVA Islas
Healthy Eating, Active Living...
FROM the LENS focus on LATINO ISSUES..
Cultiva La Salud
We are trying to MAKE SENSE of DATA
FROM COUNTY LEVEL..
LOCAL ADVOCACY
RESEARCH + FUNDING
BASELINES for EVALUATION
CHECK-IN...
WHAT would it LOOK like if there were NO BARRIERS to HEALTH in the LATINO COMMUNITY in FRESNO?
WE'VE LOOKED at SYSTEMIC INEQUITIES
PEOPLE would not be AFRAID..
core of FEAR
ACCESS to HEALTHY FOOD
CLEANER AIR
everyone HAS HOUSING
read the BIBLE!
No babies die early
Facilities + PROVIDERS
Green Space
Transportation
Healthcare, a LIVING WAGE
ALL PEOPLE get SERVICES they NEED
we see it EVERYDAY...
DIFFERENCES based on ZIPCODE, equal ACCESS to AMENITIES
CRIME RATES would DROP
land use POLICIES for walking, healthy TRANSPORTATION
more than ONE BUS
not car-centric
MY JOB would be ELIMINATED
GOING to the DR. when you AREN'T SICK
AND SPECIALISTS
WE WOULD be self-advocates. ACTIVE CIVIC PARTICIPATION
We want the BEST for EVERYONE
FAMILY
GREATER empathy for MARGINALIZED COMMUNITIES from ELECTED officials..
It's FESTIVE!! We like to CELEBRATE LIFE!

The indicators were chosen because they have "the greatest potential to have a positive effect on the health and well-being of the population and each individual within it, now and in the years to come."

ESPAÑOL

Para ver este sitio web en

Monterey County Vision



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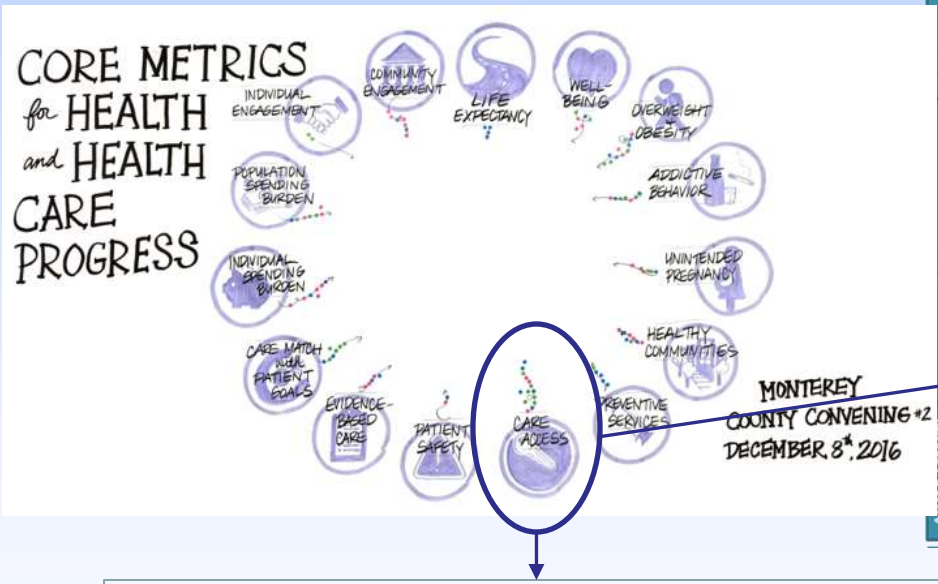
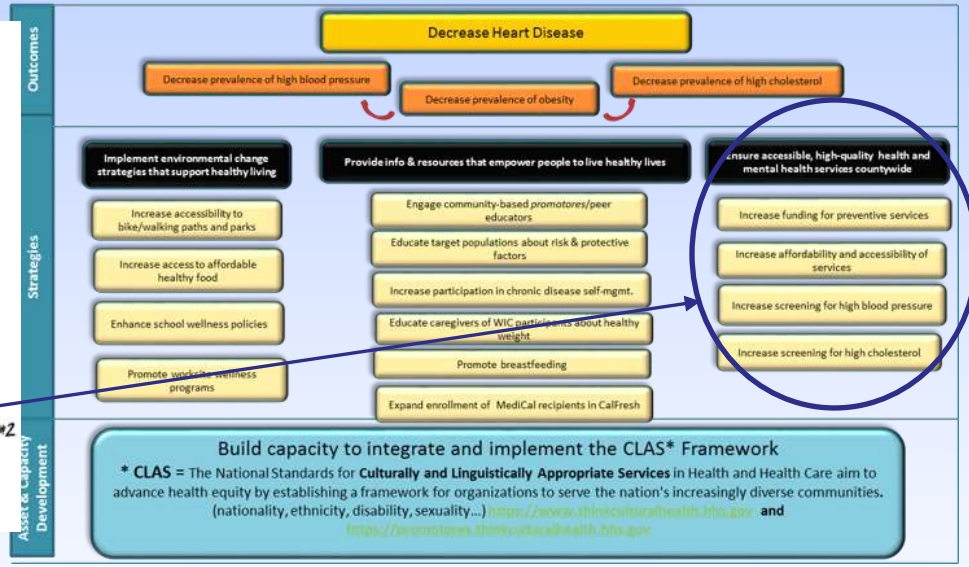
Core Metrics Supports

Community Input to Strategy Maps to Dashboards to Action

Domain Prioritization: Care Access



Strategy Map: Health



Indicators for Dashboard

(Source: California Health Interview Survey)

Had to forgo needed medical care?	2013	2015
No	25%	49%
Has/had high blood pressure?		
Yes	67%	72%

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Bonus: Adding New Partners

Cultivating Health Equity

- Who are we?
- Who are we engaging?
- Why Core Metrics is important to us?
  - Baseline data for Evaluation
  - Data for advocacy, i.e. indicators for advancing active transportation.
  - Data for planning future work i.e. funding.

CULTIVA La SALUD
Cultivating Health Equity in California's Central Valley

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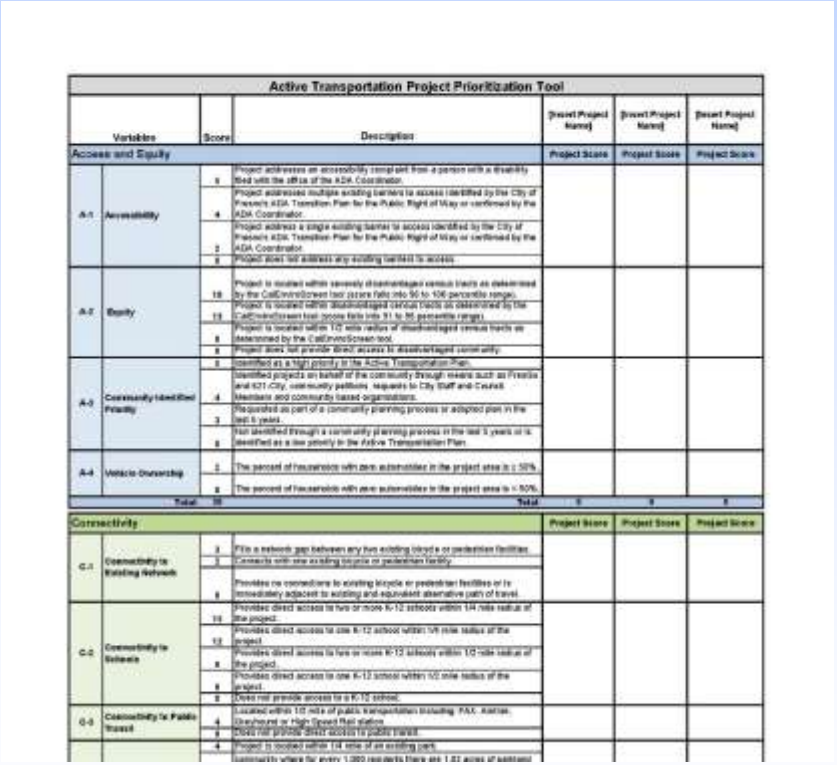
Transportation Equity

Live Stories

Fresno Active Transportation Plan



Active Transportation Project Prioritization Tool

Variables		Score	Description	[Insert Project Name]	[Insert Project Name]	[Insert Project Name]
Access and Equity				Project Score	Project Score	Project Score
A-1	Accessibility	5	Project addresses an accessibility complaint from a person with a disability filed with the office of the ADA Coordinator.			
		4	Project addresses multiple existing barriers to access identified by the City of Fresno's ADA Transition Plan for the Public Right of Way or confirmed by the ADA Coordinator.			
		2	Project addresses a single existing barrier to access identified by the City of Fresno's ADA Transition Plan for the Public Right of Way or confirmed by the ADA Coordinator.			
		0	Project does not address any existing barriers to access.			
A-2	Equity	15	Project is located within severely disadvantaged census tracts as determined by the CalEnviroScreen tool (scores falls into 90 to 100 percentile range).			
		10	Project is located within disadvantaged census tracts as determined by the CalEnviroScreen tool (scores falls into 91 to 95 percentile range).			
		5	Project is located within 1/2 mile radius of disadvantaged census tracts as determined by the CalEnviroScreen tool.			
		0	Project does not provide direct access to disadvantaged community.			
A-3	Community Identified Priority	5	Identified as a high priority in the Active Transportation Plan.			
		4	Identified projects on behalf of the community through means such as Fresno and 621 City, community petitions requests to City Staff and Council Members and community based organizations.			
		3	Requested as part of a community planning process or adopted plan in the last 5 years.			
		0	Not identified through a community planning process in the last 5 years or is identified as a low priority in the Active Transportation Plan.			
A-4	Vehicle Ownership	3	The percent of households with zero automobiles in the project area is ≥ 50%.			
		0	The percent of households with zero automobiles in the project area is < 50%.			
Total		15		Total	0	0
Connectivity				Project Score	Project Score	Project Score
C-1	Connectivity to Existing Network	3	Fills a network gap between any two existing bicycle or pedestrian facilities.			
		2	Connects with one existing bicycle or pedestrian facility.			
		0	Provides no connections to existing bicycle or pedestrian facilities or is immediately adjacent to existing and equivalent alternative path of travel.			
C-2	Connectivity to Schools	10	Provides direct access to two or more K-12 schools within 1/4 mile radius of the project.			
		12	Provides direct access to one K-12 school within 1/4 mile radius of the project.			
		8	Provides direct access to two or more K-12 schools within 1/2 mile radius of the project.			
		6	Provides direct access to one K-12 school within 1/2 mile radius of the project.			
		0	Does not provide access to a K-12 school.			
C-3	Connectivity to Public Transit	4	Located within 1/2 mile of public transportation including: FAX, Amtrak, Greyhound or High Speed Rail station.			
		0	Does not provide direct access to public transit.			
		4	Project is located within 1/4 mile of an existing park.			

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Data Compilation: Healthy People

	National?	State?	County?	Sub-County?
Self-reported health	Yes	Yes	Yes	Yes
Body mass index	Yes	Yes	Yes	Yes
Life expectancy	Yes	Yes	Yes	No
High school graduation rate	Yes	Yes	Yes	Yes
Addiction death rate	Yes	Yes	Yes	No
Teen pregnancy	Yes	Yes	Yes	No
Available without conducting additional analyses				

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Data Compilation: Care Quality

	National?	State?	County?	Sub-County?
Childhood immunization rates	Yes	Yes	Yes	Yes
Unmet care need	Yes	Yes	Yes	No
Hospital-acquired infection rate	Yes	Yes	Yes	Yes
Preventable hospitalization rate	Yes	Yes	Yes	No
Patient-clinician communication	Yes	Yes	Yes	No

Available without conducting additional analyses

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Data Compilation: Care Cost

	National?	State?	County?	Sub-County?
High spending relative to income	Yes	No	No	No
Per capita expenditures on healthcare	Yes	Yes	Yes	No
Available without conducting additional analyses				

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Data Compilation: Engaged People

	National?	State?	County?	Sub-County?
Health literacy	Yes	**No**	**No**	**No**
Social support	Yes	**No**	**No**	**No**
Available without conducting additional analyses				

Live Stories Sites (English)

- Fresno : http://bit.ly/2rCmhsB
- Fresno Active Transportation: http://bit.ly/2rWuYi8
- Monterey: http://bit.ly/2rWtW5E

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Summary

- The Vital Signs data can be obtained
- Providing the data centrally allows communities to focus on using data, not collecting it
- Communities have existing data processes in place
  - Letting go of all that data is hard
- Telling stories with the community adds meaning and value

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Reaction Panel

Peter Long,
Blue Shield California Foundation

Elizabeth Mitchell,
Network for Regional Healthcare Improvement

Alina Baciu,
NASEM Roundtable on Population Health Improvement

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Peter Long, PhD

President and CEO
Blue Shield of California Foundation

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Elizabeth Mitchell

President and CEO
Network for Regional Healthcare Improvement

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nrhi

Network for
Regional Healthcare
Improvement

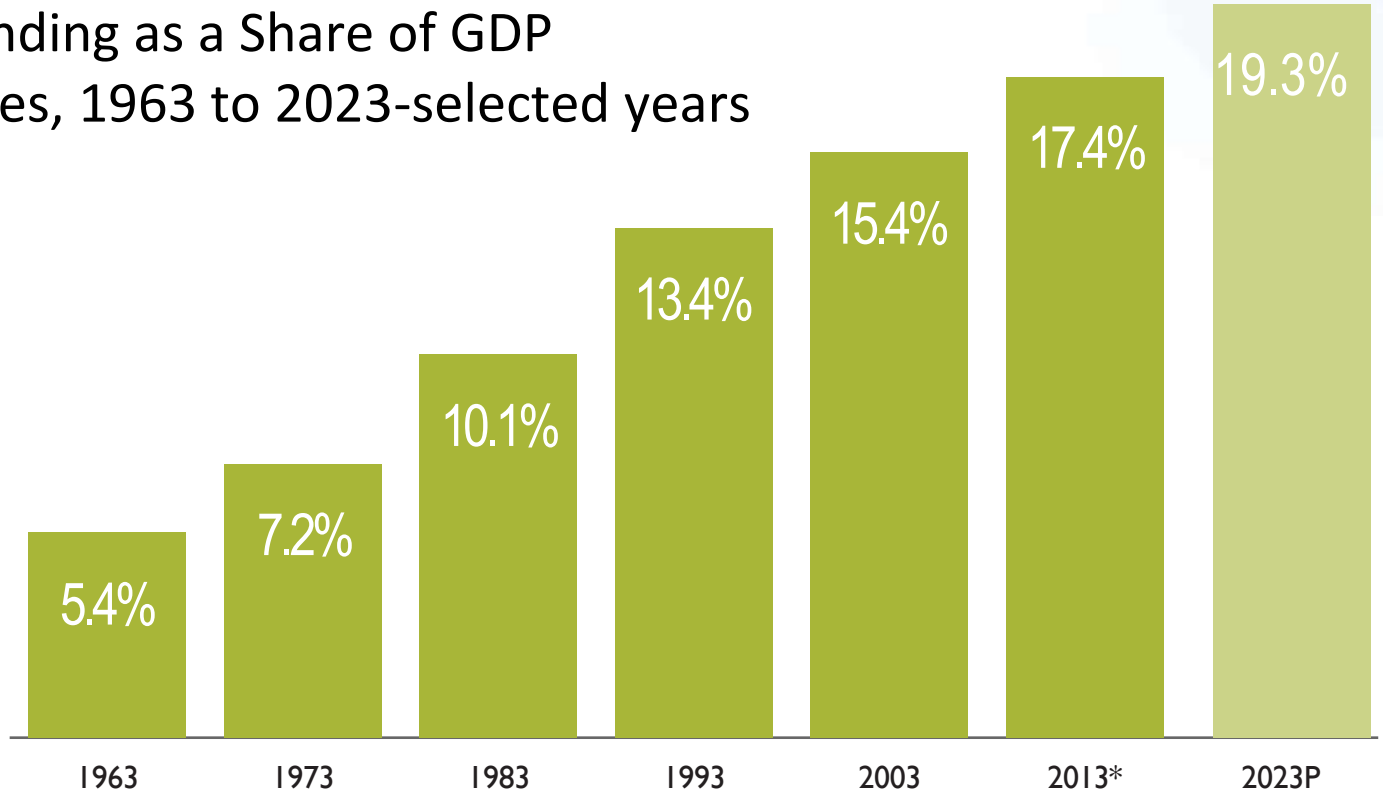
Power of Regional Data for Common Measurement

Elizabeth Mitchell, President & CEO

Network for Regional Healthcare Improvement

We have a problem

Health Spending as a Share of GDP
United States, 1963 to 2023-selected years



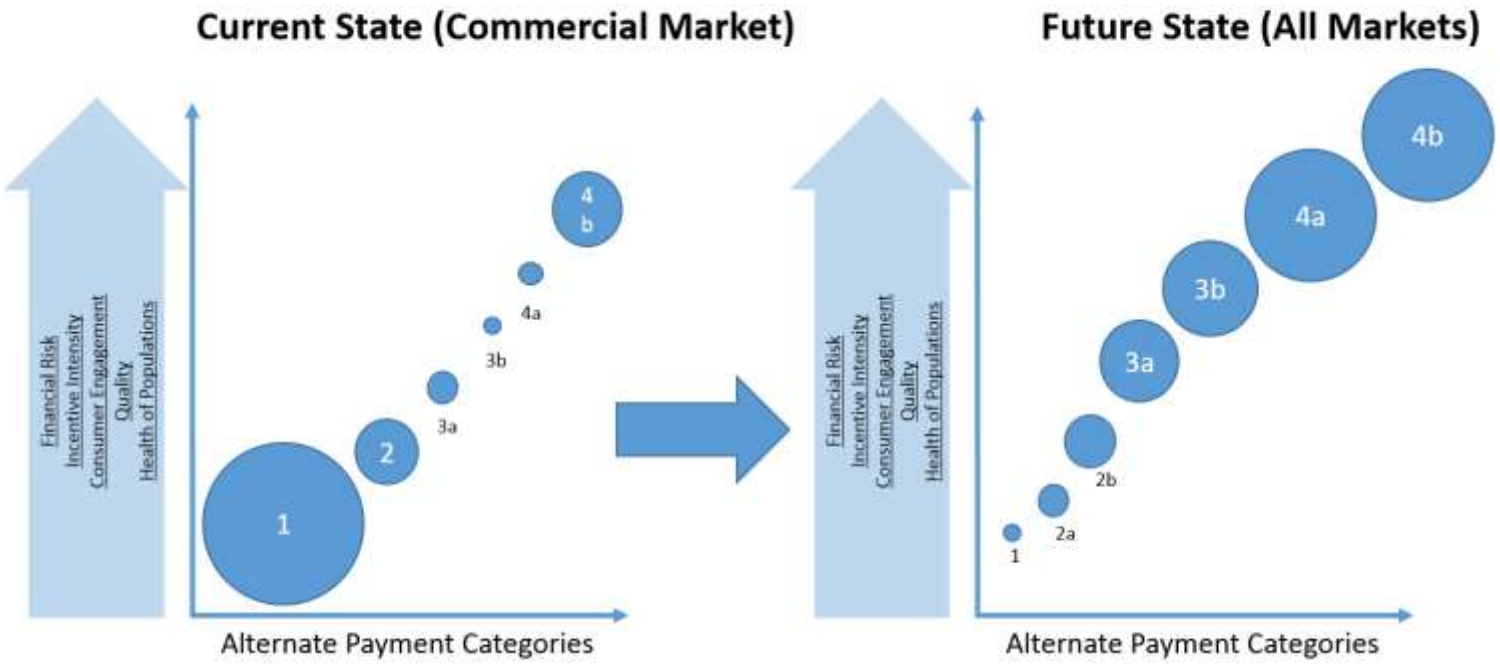
*2013 figure reflects a 3.1% increase in gross domestic product (GDP) and a 3.6% increase in national health spending over the prior year. See page 27 for a comparison of economic growth and health spending growth.

Notes: *Health spending* refers to national health expenditures. Projections shown as *P*.

Source: "National Health Expenditure Data," Centers for Medicare & Medicaid Services (CMS), 2014 (historical) and 2015 (projections), www.cms.gov.

Over time, the desire is to influence a shift in payment models to Categories 3 and 4

<u>Conceptual</u> diagram of the desired shift in payment model application given the current state of the commercial market*



Note:

- Size of "bubble" indicates overall investment in each category of APM
- Over time, APMs will move up the Y-axis and there will be more investment in the higher categories

HCP LAN
Health Care Payment Learning & Action Network

Source: CPR 2014 National Scorecard on Payment Reform, based on the National commercial market using 2013 data.

From FFS to PBP: Some Changes Required

- New measures – quality and cost
- New shared data infrastructure
- New incentives
- Transparency
- Alignment across payers
- New care models
- New community partners
- New relationships

What GAO Found

- 5% of measures used by commercial plans were common
- Physician practices spend 785+ hours per physician per year on quality measurement
- Average annual cost of quality measurement per physician is $40,000+

Factors Driving Misalignment of Health Care Quality Measures

Factor	Description
Dispersed decision-making	Among public and private payers and other stakeholders, each entity independently decides which quality measures it will use and which specifications should apply to those measures.
Variation in data collection and reporting systems	Payers may choose different measures, modify existing measures, or leave details about measure specifications up to providers in order to accommodate differences in data that providers collect and the systems they use to collect these data.
Few meaningful measures	Although hundreds of quality measures have been developed, relatively few are measures that payers, providers, and other stakeholders agree to adopt, because few are viewed as leading to meaningful improvements in quality.

Source: GAO interviews with Department of Health and Human Services officials and experts. | GAO-17-5

Background: Total Cost of Care

Robert Wood Johnson Foundation

nrhi Network for Regional Healthcare Improvement

Getting to Affordability

REGIONAL COMMITMENT. NATIONAL IMPACT.

The initiative was piloted by NRHI and RHICs in five regions. Their success led to the expansion to nine additional regions over the course of the project.

Pilot RHICs

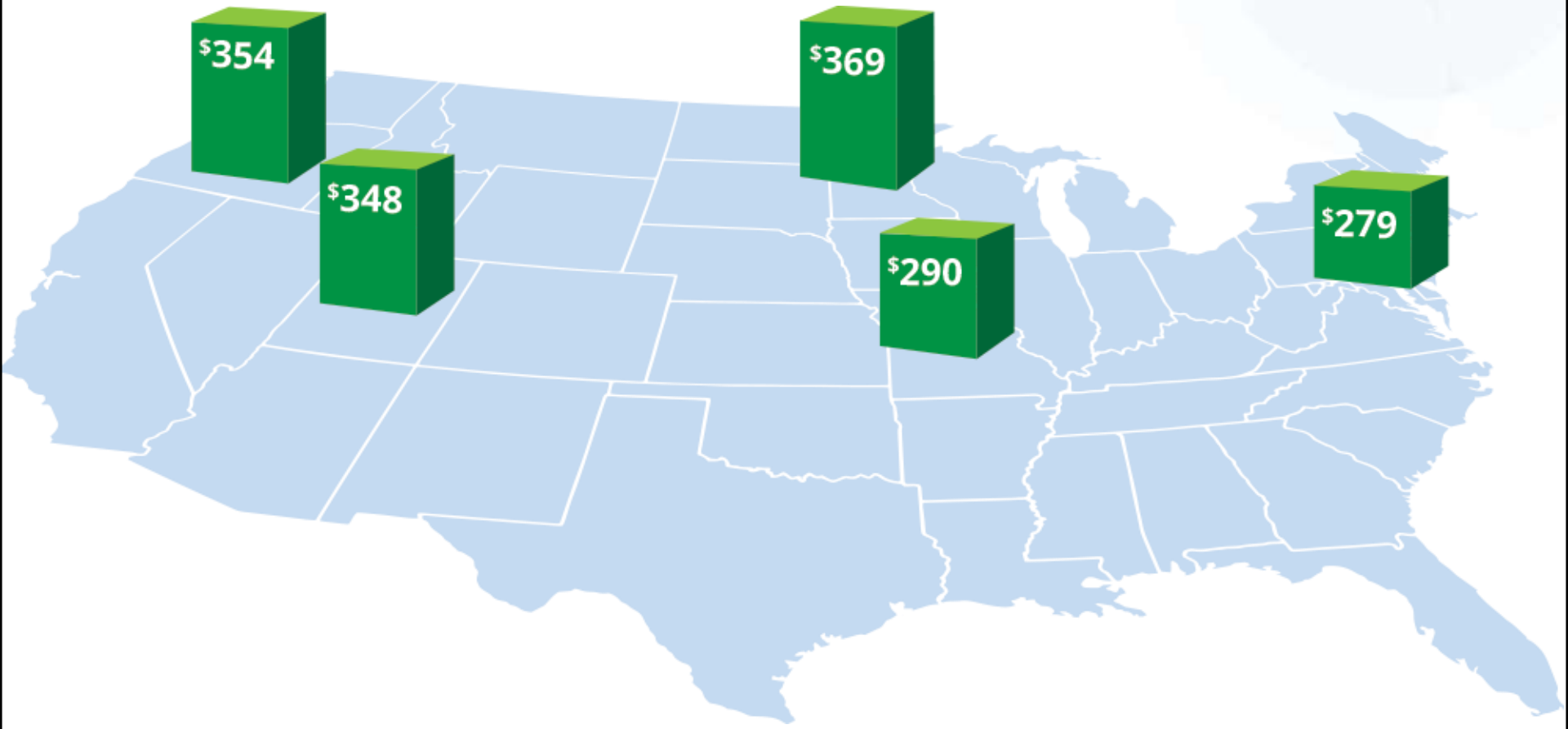
Center for Improving Value in Health Care | Colorado
Maine Health Management Coalition | Maine*
Midwest Health Initiative | St. Louis, Missouri
Minnesota Community Measurement | Minnesota
Oregon Health Care Quality Corporation | Oregon

Expansion Regions

HealthInsight Utah | Utah
Health Care Improvement Foundation | Philadelphia
The Health Collaborative | Ohio
Maryland Health Care Commission | Maryland
Massachusetts Health Quality Partners | Massachusetts
The University of Texas Health Science Center at Houston | Texas
Virginia Health Information | Virginia
Washington Health Alliance | Washington
Wisconsin Health Information Organization | Wisconsin

**Phase I and II only participant*

We now have some information!



2014 commercial multi-payer claims

Variation Exists

Total Cost Index and Resource Use Index:

Commercial Population 2014

Combined Attributed and Unattributed

Measure	**HI** Utah	**MHCC** Maryland	**MHI** St. Louis, MO	**MNCM** Minnesota	**Q CORP** Oregon
Risk Adjusted Total PMPM Per Member Per Month	$348	$279	$290	$369	$354
TCI Price x Utilization	1.07	0.86	0.89	1.13	1.09
RUI Utilization	1.08	0.88	1.08	1.05	0.93
PI Price Index	0.99	0.97	0.82	1.08	1.17

This work is based on the patented algorithm of HealthPartners, Inc. (Bloomington, MN) and is used with their permission

What's driving the variation?

Components of Medical Cost

Commercial Population 2014
Combined Attributed and Unattributed

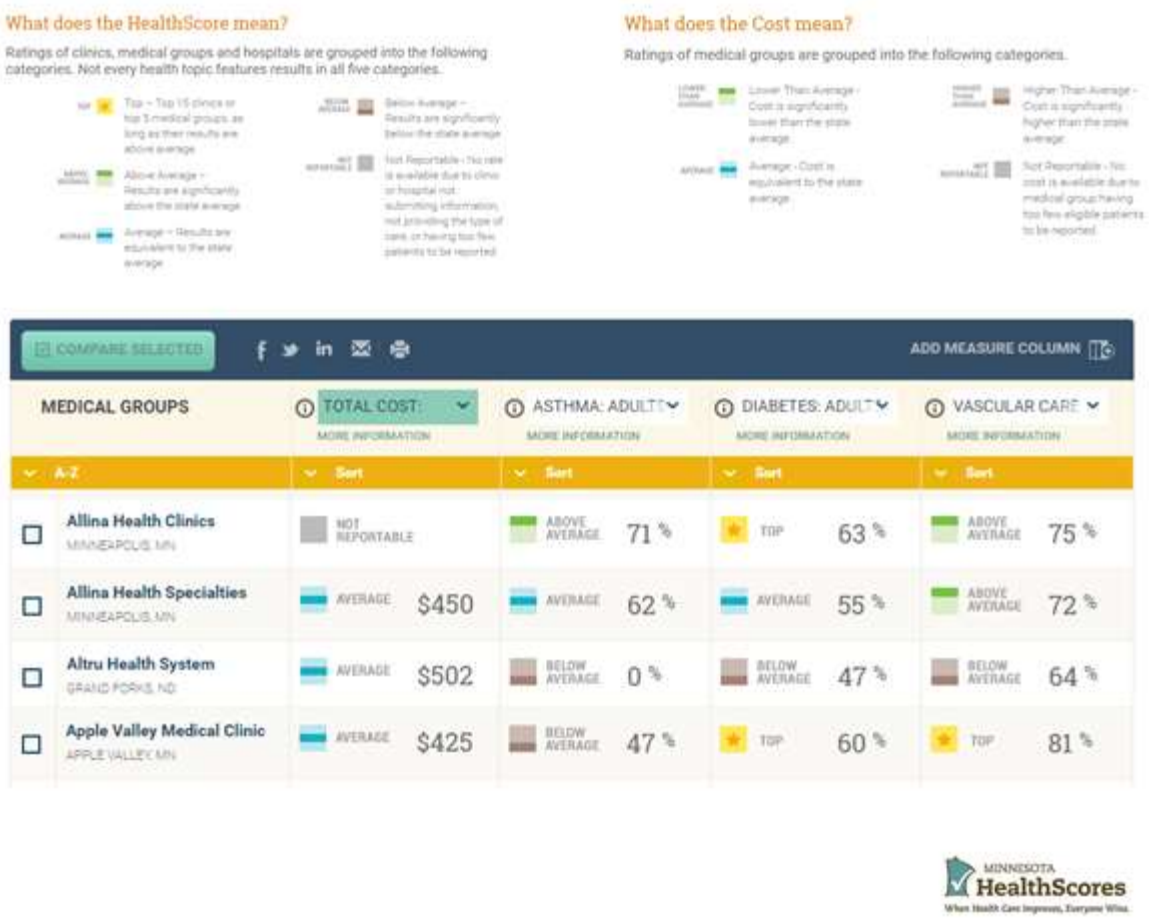
Measure	HI Utah	MHCC Maryland	MHI St. Louis, MO	MNCM Minnesota	Q CORP Oregon
TCI					
Overall	1.07	0.86	0.89	1.13	1.09
Inpatient	1.45	0.62	0.82	1.12	1.08
Outpatient	1.15	0.67	0.97	1.09	1.17
Professional	0.94	0.90	0.76	1.26	1.16
Pharmacy	0.91	1.16	1.09	0.95	0.86
RUI					
Overall	1.08	0.88	1.08	1.05	0.93
Inpatient	1.57	0.63	1.03	1.01	0.85
Outpatient	1.21	0.52	1.25	1.07	0.99
Professional	0.93	1.05	0.96	1.07	0.97
Pharmacy	0.93	1.14	0.96	1.06	0.88
Price Index					
Overall	0.99	0.97	0.82	1.08	1.17
Inpatient	0.93	0.98	0.79	1.11	1.27
Outpatient	0.95	1.28	0.77	1.02	1.18
Professional	1.01	0.86	0.79	1.18	1.19
Pharmacy	0.98	1.02	1.13	0.89	0.98

This work is based on the patented algorithm of HealthPartners, Inc. (Bloomington, MN) and is used with their permission

Key Take-Aways

- Standardization enables data transparency across regions
- Standardized data cleaning can be replicated and spread
- Barriers open up stakeholder dialog leading to solutions
- This information enables stakeholders to change the way they participate in the marketplace
  - Employer/Purchasers
  - Healthcare Providers
  - Policymakers
  - Health Plans

Local Benchmarking & Public Reporting



Primary Care Practice Report

	Practice		BM[2]	
	Raw PMPM	Adj PMPM*	PMPM	TCI
Inpatient Fac.	$82	$77	$98	0.78
Outpatient Fac.	$175	$164	$196	0.84
Professional	$152	$142	$146	0.97
Pharmacy	$94	$88	$93	0.94
Overall	***$503***	***$470***	*$533*	*0.88*

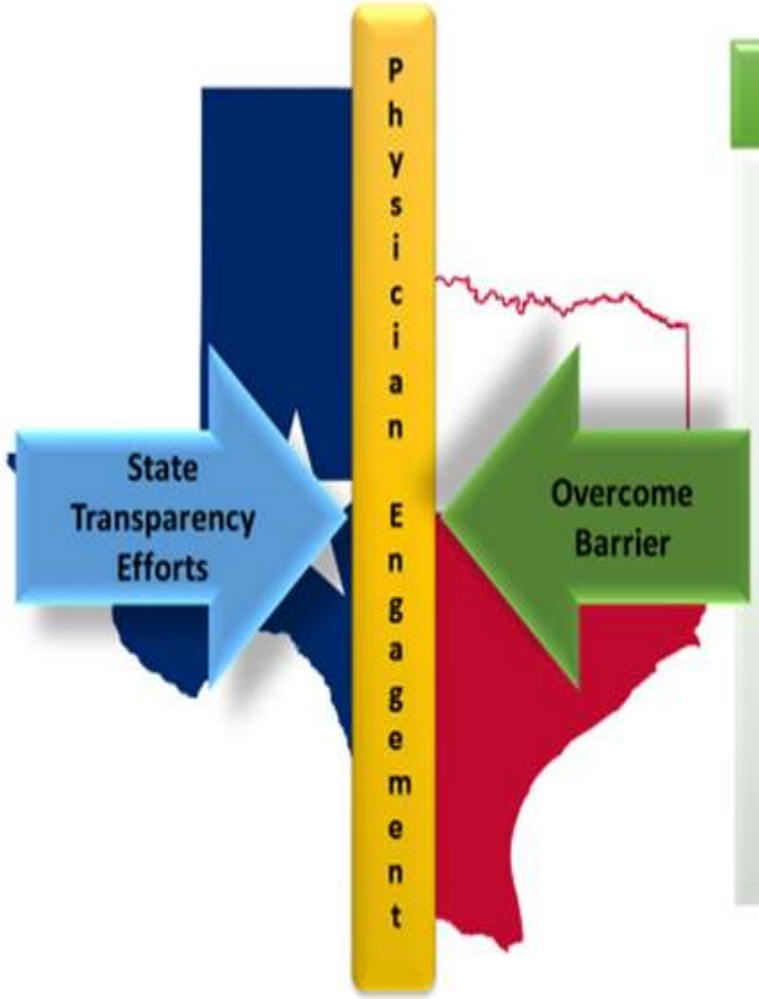
Maine Health Management Coalition

[2] BM = Peer Benchmark

Note: Retrospective Risk Score for Practice = 1.07

Displayed as an index to protect information while being transparent with relative performance.

The Barrier: Physician Engagement in Transparency



Strategy	Actions	Results
- Persuade providers on importance of transparency - Engage them early on in the process - Active participants & incorporate feedback	- Reached out to physician organizations and associations - Organized "think tanks" with physicians representing all type of practices -Invited selected physicians to NRHI G2A - Propose approaches; use recommended	- Physician Champions, supporting initiative - Agreement with the support of the Think Tank to begin reporting - Select measures by creating an Atlas of the Health of Texas (Atlas) - Physician and physician Association (TMA) support for the initiative

Leveraging Stakeholder Shared Interests

How Physicians Think Employers are Going to Respond to Cost Data

How Employers Actually Respond to Cost Data

MIDWEST HEALTH INITIATIVE

Challenges

- Too many, unaligned cost measures adds to the measure noise and inaction
- Obtaining permission to utilize actual health plan and member allowed amounts
- Harmonizing data from multiple sources
- Common risk adjustment for comparative purposes
- Resources and leadership

How We Did It

- Facilitate community dialog at a common, neutral table
- Data flows at the speed of trust
- Standardize where necessary; customize for local utilization
- Leverage local market intelligence and expertise
- Collaboration across regions to spread best practices
- Central leadership and support
- Clean data at the level necessary to be fit for purpose
- Philanthropic support

NRHI Membership

Better Health Partnership – Ohio
Center for Improving Value in Health Care – Colorado
Common Ground Health – New York
Community First – Hawaii
Greater Detroit Area Health Council – Michigan
Health Care Improvement Foundation – Pennsylvania
HealthInsight – Nevada
HealthInsight – New Mexico
HealthInsight – Utah
Healthcare Collaborative of Greater Columbus – Ohio
Institute for Clinical Systems Improvement – Minnesota
Integrated Healthcare Association – California
Iowa Healthcare Collaborative – Iowa
Kentuckiana Health Collaborative – Kentucky
Louisiana Health Care Quality Forum – Louisiana
Maine Health Management Coalition – Maine
Maine Quality Counts – Maine
Massachusetts Health Quality Partners – Massachusetts
Midwest Health Initiative – Missouri
Minnesota Community Measurement – Minnesota
Mountain-Pacific Quality Health – Montana
MyHealth Access Network – Oklahoma
New Jersey Health Care Quality Institute – New Jersey
North Coast Health Improvement and Information Network – California
Oregon Health Care Quality Corporation – Oregon
Pacific Business Group on Health – California
Pittsburgh Regional Health Initiative – Pennsylvania
The Health Collaborative – Ohio
Washington Health Alliance – Washington
WellSpan Health– Pennsylvania
Wisconsin Collaborative for Healthcare Quality – Wisconsin
Wisconsin Health Information Organization – Wisconsin

State Affiliated Partners

Integrated Healthcare Association - California
State of Maryland Health Care Commission – Maryland
University of Texas/UTHealth - Texas

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Alina Baciu, MPH, PhD

Senior Program Officer & Director of Roundtable on Population Health Improvement
National Academies of Sciences, Engineering & Medicine

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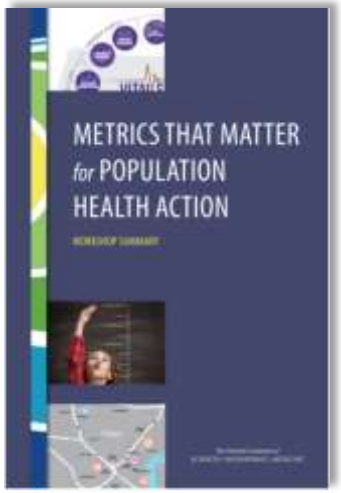
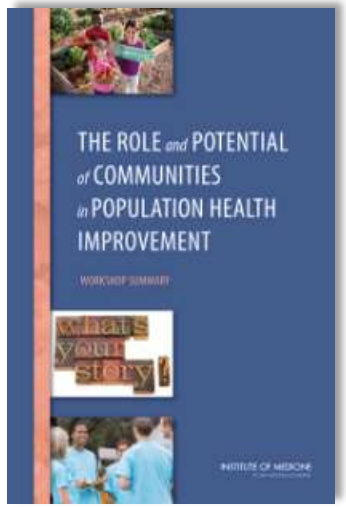
Metrics Beyond Health Care

Themes in Roundtable's workshops & dialogue resonate with *Vital Signs* metrics implementation in California:

- Authentically community-driven (only way to address legacy of systemic inequities, exclusion, etc.)
- Fit for purpose (e.g. what's the problem we're trying to fix)
- Relevant to action (extant data, actions that can be undertaken)
- Cross-sector collaboration





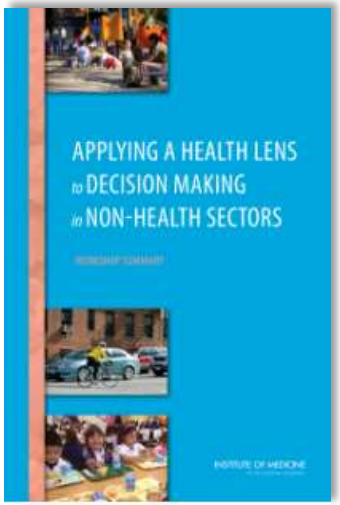
ROUNDTABLE ON POPULATION HEALTH IMPROVEMENT

The National Academies of SCIENCES · ENGINEERING · MEDICINE

Metrics Beyond Health Care

Roundtable-associated publications & perspectives highlight: How public health, health care, and other sectors use measures collaboratively to improve community health & well-being, and how non-health measures can be used by health systems to address patients' health-related social needs.

Roundtable focus: Non-clinical metrics (e.g., social determinants of health) related to *Vital Signs* priority measures in #6 Health Community & #15 Community Engagement.



ROUNDTABLE ON POPULATION HEALTH IMPROVEMENT

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Q & A

Please type your questions in the Q & A box at the lower right-hand corner.

Provide your name and organization.

If applicable, please specify who you are directing your question to.

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NAM Vital Signs Wants to Hear From You:

Activities: Which organizations are applying the Vital Signs framework?

Linkages: How can we align driver measures or process levers with Vital Signs?

Measures: What datasets and composite measures have been most useful?

Partnership: How should we build a learning network and user toolkit?

Contact: Claire Wang, cwang@nas.edu

Join the Vital Signs Mailing List at nam.edu/VitalSigns

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Related Resources

Publications|

Observations from the Field: Reporting Quality Metrics in Health Care. (2016) NAM Discussion Paper, by Dunlap et al.

Metrics That Matter for Population Health Action: Workshop Summary (2016) nam.edu/Perspectives

Events|

Publication Release: *Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health*. nam.edu/HighNeeds. July 6, 2017

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