# Core Metrics Pilot Project
# Final Report

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## Table of Contents

# Executive Summary

The Blue Shield of California Foundation sponsored an Institute of Medicine (IOM) workshop on core metrics which led to the formation of an IOM Committee to develop a set of Core Metrics. The Committee's report, *Vital Signs: Core Metrics for Health and Health Care Progress*, was released in April, 2015. The report identifies national metrics in four domains: healthy people (also referred to as population health), quality of healthcare, cost of healthcare, and engagement. The report provides national estimates for each domain's indicators. However, these metrics were not estimated at the local level. Furthermore, it was unknown if they could be implemented and used at the local level by government agencies; in Community Health Needs Assessments (CHNAs); by healthcare providers, such as federally qualified health clinics (FQHC's); and many other stakeholders. This project studies the feasibility of implementing the Core Metrics and report recommendations in Monterey County and Fresno County, California. This project demonstrated that health information can be developed at a local level, the Core Metrics concretely specified, and that the measures are practical, understandable, and usable.

We developed partnerships with two existing community coalition groups, one led by the Public Health Institute's Cultiva la Salud in Fresno County and the other facilitated by a backbone of several county organizations including the Monterey County Health Department. Representatives from each group were composed of members from public health, healthcare, and community-based organizations. Two in-person convenings were held with each site. During the first convening, we gathered in-depth information on current indicator projects and community priorities. During the second convening, we presented and gathered feedback on custom websites created using LiveStories, a storytelling platform that combines images, charts, maps, videos, and rich text to tell a story, for each group and facilitated discussions about how the websites would be used to drive action in ways that were important for each community.[1] To build the websites, we used public-use datasets and reports for each of the Core Metrics indicators. We also supplemented the Core Metrics indicators with one additional unique indicator for each site (*Active Transportation* in Fresno, *Safety and Health* in Monterey) and built custom websites featuring these indicators.[2]

We led the project using a community-based participatory process to engage stakeholders. This fostered community-defined, actionable metrics. From our perspective, it is clear that the Core Metrics indicator set must be tailored for each community in order for it to be meaningful for that community.

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[1] Fresno Core Metrics: https://insight.livestories.com/s/v2/fresno-county-core-metrics-overview/18574b4e-a48c-4537-adb5-3dae7b63f59f
Monterey Core Metrics: https://insight.livestories.com/s/v2/monterey-county-core-metrics-overview/c3f8ed0a-87ec-4267-92fd-6e9cb4a56b8b/

[2] Fresno Active Transportation: https://insight.livestories.com/s/v2/fresno-active-transportation-overview/d3571c3e-a515-4ff8-9193-447a05dd8bc4/
Monterey Safety and Health: https://insight.livestories.com/s/v2/safety-and-health-in-monterey/d3947d2c-6804-4438-879c-17677d5d904d/

Through the data compilation process, we determined that most of the Best Current Measures in the Vital Signs report were available at the county level (12 of 15 measures), and some were available at the sub-county level (5 of 15 measures). One challenge was that sometimes, national measures (such as health literacy) were not available at the local level, so we used proxies (English language literacy, voter turnout). To our knowledge, both communities will continue to use the LiveStories platform and the Core Metrics websites to promote their work and drive action to improve public health. Prior to the end of our project, our team trained representatives from both demonstration sites on how to use LiveStories, including how to update content on the sites (photos, text, and data).

Virtually every community in the United States has at least one indicator project underway. Our project's findings demonstrate that the Core Metrics can fit in with existing efforts (such as with the Community Health Needs Assessment in Fresno, or Impact Monterey County), and it can be adapted so it is meaningful for communities and provides indicators that are important for their work. The question we are left with is: do the Core Metrics add value to existing data projects? We observed in this pilot project that they do. Future plans include expanding the Core Metrics for use throughout California and nationwide.

# Introduction

This report describes our experience implementing the Vital Sign's Core Metrics in two communities in California. The report is organized in chronological order of our work with these two communities. First, we provide background about the project and its purpose. Second, we describe the process of selecting the two communities and the community-engagement activities we did with each of them: 1) interviews and surveys with community stakeholders, 2) the first convening, and 3) the second convening. Third, we describe the process of compiling the Core Metrics for each community. Fourth, we describe the overall key findings and lessons learned during this project. Fifth, we provide recommendations for replication of this project in other communities. Sixth, we include short descriptions of our work in each specific community (Fresno County, Monterey County) to illustrate the unique aspects of our work with each community. The appendices include many detailed documents that can assist other communities in replicating this project, such as the convening agendas, images created by our graphic recorder, and a sample scope of work for a community-based site.

## Background: setting for the case study

The Institute of Medicine (IOM)[3] Report on Vital Signs was released in April 2015 and presented a parsimonious set of Core Metrics which could be implemented and adopted by healthcare organizations and local communities. The concepts for the report were generated during an IOM workshop, sponsored by The Blue Shield of California Foundation. The measures and recommendations were the subsequent work of an IOM Committee. The report identifies national metrics in four domains: healthy people (also referred to as population health), quality of healthcare, cost of healthcare, and engagement. The report provides national estimates for each domain's indicators. However, these metrics were not estimated at the local level. However, these metrics were not estimated at the state or local level nor was the feasibility of doing so assessed.

What distinguishes the Core Metrics from other sets of measures, such as Healthy People and the County Health Rankings, is the imprimatur of the IOM and the broad group of experts that wrote the report. One of the major challenges of the report, however, is that while general measures were recommended, they were not specified sufficiently to be used in a consistent fashion. For example, while high school graduation was a recommended measure, it was not clear how it would be measured. It could be operationalized as the proportion of ninth graders graduating in four years or people age twenty-five who have completed high school equivalency, or any of several other measures. In addition, communities may be interested in additional topics not in the core measure set, for example housing or access to healthy food.

The value of measures is not in creating them, but in using them to drive changes that lead to health improvement and health equity. The Core Metrics focus heavily on clinical issues and are, therefore, most important for clinical care systems. However, we wanted to see how the Core Metrics could be implemented in community settings. To demonstrate how the Vital Signs recommendations could be operationalized in at the community level and how the measures can be used by key stakeholders to shape planning processes that lead to health improvement and health equity, we conducted a pilot project in two California communities.

3 When the report was released, this institution was known as the Institute of Medicine. It is currently known as the Health and Management Division of the National Academies of Science, Engineering, and Medicine.

## Summary - Experience in Monterey County

Our project successfully built LiveStories sites to help the Monterey County Health Department drive community action to improve public health. These sites displayed the Core Metrics[4] and a story focused on Safety[5], which is a key interest and focus of the Monterey County Health Department's work.


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."

- Vital Signs: Core Metrics for Health and Health Care Progress, Institute of Medicine

Excerpt from LiveStories custom website https://insight.livestories.com/s/v2/monterey-county-core-metrics-overview/c3f8ed0a-87ec-4267-92fd-6e9cb4a56b8b/

Monterey County is located on the Central Coast of California about 106 miles south of San Francisco and is a large, rural county with approximately 3,800 square miles. Its economy is primarily based upon tourism in the coastal regions, with over 3 million visitors per year, and agriculture along the Salinas River Valley, with a production value of $4.84 billion in 2015. Population was 430,000 in 2015.[6] About 55.4% of the population is Latino[7], and 30% is foreign-born.[8] Monterey County residents are

[4] Core Metrics Monterey site available here: https://insight.livestories.com/s/v2/monterey-county-core-metrics-overview/c3f8ed0a-87ec-4267-92fd-6e9cb4a56b8b/
[5] Safety in Monterey site available here: https://insight.livestories.com/s/v2/safety-and-health-in-monterey/d3947d2c-6804-4438-879c-17677d5d904d/
[6] U.S. Census Bureau. (2015). Monterey County, California DP05 ACS Demographic and Housing Estimates [Data]. *2011-2015 American Community Survey 5-Year Estimates.* Retrieved from http://factfinder.census.gov/.
[7] U.S. Census Bureau. (2010). Monterey County, California DP-1 Profile of General Population and Housing Characteristics: 2010 [Data]. *2010 Demographic Profile Data*. Retrieved from http://factfinder.census.gov/.
[8] U.S. Census Bureau. (2015). Monterey County, California B05002 Place of Birth by Nativity and Citizenship Status [Data]. *2011-2015 American Community Survey 5-Year Estimates.* Retrieved from

relatively young with a median age of 33 years.[5] Seventeen percent of persons live in poverty.[9] Fifty-nine percent of children five years old and younger are enrolled in Medi-Cal.[10] The annual unemployment rate was 8.4% in 2015 compared to 9.9% for California.[11] In 2013, Monterey County had the highest homicide rate among victims of ages 10 to 24; its rate was three times the statewide average of 8.22 per 100,000.[12]

In Monterey County, many indicator projects were underway when our PHI implementation team began to work with the community leader, Krista Hanni. Dr. Hanni is the Planning, Evaluation, and Policy Manager at the Monterey County Health Department. PHI had worked with her previously, however, no one on our implementation team had done so. Consequently, several group phone calls allowed us to develop rapport for the project.

The work at the Monterey County Health Department was characterized by collaboratives that brought together members of diverse organizations (government agencies, non-profit organizations, healthcare organizations) to work towards improving public health and the quality of life for all Monterey County residents. Dr. Hanni's collaborators included the United Way, which had recently completed a community-wide health assessment (Impact Monterey County) which included surveys of about 4,000 Monterey County residents in English and Spanish and community focus groups in English and Spanish. In addition, as an employee of a local health department Dr. Hanni had access to many datasets and had established relationships with other government agencies, such as the Department of Social Services, and healthcare organizations.

In Monterey County, our collaborators had access to a great deal of data – so much data that it was a challenge to present it in meaningful, targeted ways so that it could be used to drive actions to improve public health. Our project provided an opportunity for the Monterey County group to focus their efforts on a more limited set of metrics, fill in some gaps in their existing metrics, and also incorporate standardized criteria (from the Vital Signs report, Box S-2) to improve the quality of the metrics that they use (such as the Impact Monterey County dataset). Our pilot project helped Dr. Hanni provide leadership and vision to the collaboratives she wor
ked with and allowed her to develop a concrete product (LiveStories sites) that could be shared with the public and used to drive public health action. Furthermore, Dr. Hanni saw our project as fitting into a complex process that involved multiple stakeholders and organizations (non-profit, government, healthcare) in Monterey County, of which she was an active member. The LiveStories sites were not the end for this project- rather, they were a step in the process of collaborative work that Dr. Hanni leads as a senior leader in the Monterey County Health Department.

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http://factfinder.census.gov/.

[9] U.S. Census Bureau. (2015). Monterey County, California DP03 Selected Economic Characteristics [Data]. *2011-2015 American Community Survey 5-Year Estimates.* Retrieved from http://factfinder.census.gov/.

[10] U.S. Census Bureau. (2011-2015). Monterey County, California S2704. Public Health Insurance by Type [Data]. *2011-2015 American Community Survey 5-Year Estimates*. Retrieved from http://factfinder.census.gov/

[11] U.S. Census Bureau. (2011-2015). Monterey County, California and California DP03. Selected Economic Characteristics [Data]. *2011-2015 American Community Survey 5-Year Estimates*. Retrieved from http://factfinder.census.gov/

[12] Langley, M. & Sugarmann, J. (2015). Youth lost: A county-by-county analysis of 2013 California homicide victims ages 10 to 24. Violence Policy Center. Retrieved from http://www.vpc.org/studies/cayouth2015.pdf

## Summary - Experience in Fresno County

Our project successfully built LiveStories sites to help Cultiva la Salud drive community action to improve public health. Because the focus of Cultiva la Salud is to work with the Latino community, these sites displayed the Core Metrics[13], with a specific focus on statistics for Latinos whenever possible, and a story focused on Active Transportation[14], which is a key interest and focus of Cultiva la Salud's work.


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."

- Vital Signs: Core Metrics for Health and Health Care Progress, Institute of Medicine

Excerpt from LiveStories custom website https://insight.livestories.com/s/v2/fresno-county-core-metrics-overview/18574b4e-a48c-4537-adb5-3dae7b63f59f/

Fresno County is located in California's San Joaquin Valley and has a population of nearly 1 million residents.[15] Its economy is based primarily in agriculture. The majority of residents are Hispanic or Latino (52%), and about one-quarter of residents are foreign-born (21%).[16] The median age of the population is 31 years old.[13] Twenty-two percent of the population lives under the federal poverty level,[17] and 66% of children five years old and younger receive Medi-Cal.[18]

[13] Core Metrics Fresno site available here: https://insight.livestories.com/s/v2/fresno-county-core-metrics-overview/18574b4e-a48c-4537-adb5-3dae7b63f59f

[14] Active Transportation Fresno site available here: https://insight.livestories.com/s/v2/fresno-active-transportation-overview/d3571c3e-a515-4ff8-9193-447a05dd8bc4/

[15] U.S. Census Bureau. (2010). Fresno County, California DP-1 Profile of General Population and Housing Characteristics: 2010 [Data]. *2010 Demographic Profile Data*. Retrieved from http://factfinder.census.gov/.

[16] U.S. Census Bureau. (2015). Fresno County, California. Selected Characteristics of the Native and Foreign-Born Populations [Data]. *2011-2015 American Community Survey 5-Year Estimates.* Retrieved from http://factfinder.census.gov/.

[17] U.S. Census Bureau. (2011-2015). Fresno County, California and California DP03. Selected Economic

Many indicator projects were underway when we began our work with Fresno County. However, some groups were not able to access these data. We began our work in Fresno County working in partnership with a community-based organization, Cultiva la Salud, and the Fresno County Public Health Department. However, as we began to move forward with the project, we discovered that the vision of the Fresno County Public Health Department for the project differed from ours and that of Cultiva la Salud. For this reason, we decided to invite representatives from the Fresno County Public Health Department to participate as a stakeholder in the project, but that Cultiva la Salud would provide community-based leadership and serve as a champion for the project.

Cultiva La Salud is dedicated to creating health equity in the San Joaquin Valley by fostering changes in communities that support healthy eating and active living. Cultiva La Salud uses a policy and environmental change approach to help community members gain access to healthy food, beverages and safe places to be physically active. At the core of Cultiva La Salud's efforts, is the "grassroots community" who are the catalyst and reason behind real change in communities. Cultiva la Salud strived to have access to data about the communities they worked with to drive action. The Fresno County Public Health Department functioned as the data gatekeeper in the community and, at the time our project commenced, had not granted data access to Cultiva la Salud. This was the main catalyst for Genoveva Islas, the Executive Director of Cultiva la Salud, to partner with us on this pilot project. She strived to tell the story of why change was needed in the communities where her organization worked. Cultiva La Salud plans to continue to use LiveStories to maintain the Core Metrics website and build additional sites to provide data to drive action around issues that are critical to their work.

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Characteristics [Data]. *2011-2015 American Community Survey 5-Year Estimates*. Retrieved from http://factfinder.census.gov/

[18] U.S. Census Bureau. (2011-2015). Fresno County, California S2704. Public Health Insurance by Type [Data]. *2011-2015 American Community Survey 5-Year Estimates*. Retrieved from http://factfinder.census.gov/

## Implementing the Core Metrics in Two Communities

We implemented the Core Metrics in two demonstration communities in Fresno and Monterey Counties in California. Our general approach focused on three aspects. First, we aimed to engage community members in every step of the process. Second, we aimed to include publicly available data from national, state, and local datasets. We received Institutional Review Board approval for our project from the Public Health Institute (Appendix 1). Third, we wanted to tell stories about the data and make the measures and the stories publicly available through an easily accessible web site, built using LiveStories.[19]

Our implementation process began with site recruitment. Next, we conducted interviews and surveys with stakeholders in each community. Then, we held the first convening to find out how the communities planned to utilize the Core Metrics, what focus each community's project would have, and additional supplemental indicators to fill in any gaps identified in the Core Metrics best current measures set. After the first convening, we compiled data for each community and built custom websites to display the Core Metrics for each community. Once the websites were complete, we held a second convening to present the websites to the community, discuss revisions, and decide on next steps for the Core Metrics work in each community. During the second convening, we conducted a survey of all participants to evaluate the results of our work with each community. At the convenings, we used a professional facilitator and, wherever possible, a graphic recorder to increase participant engagement and understanding. Finally, we transferred the contents of the custom websites to staff at each of the community-based sites so they could take ownership of the sites and continue to use them to promote their work. Below, we describe each component of our implementation in detail.

### Recruitment

To identify and recruit two communities for our pilot project, we used the following criteria: 1) having an existing multi-stakeholder collaborative with representation from both the public health and healthcare sectors; 2) current ability to collect and use metrics, including their engagement in related population health activities; 3) representation of different types of community, e.g., urban or rural; 4) geographic and ethnic diversity; 5) current engagement of Public Health Institute's staff within the community; 6) how well the goals of our pilot project match the interests and needs of the community; and 7) how well identification of a core set of population health metrics could advance their community's priorities.

After initial conversations with our funder to assure agreement on the criteria, PHI staff identified several sites in CA that met the criteria. Early on, there was consideration of working with a large urban jurisdiction but the team felt that the complexity of doing so as part of a pilot project would be too challenging from a management and data perspective.

In Monterey County, we approached the Central California Alliance for Health and found there was interest. We had subsequent discussions with Krista Hanni (Monterey County Policy and Planning Manager) and Yuri Anderson (United Way – Impact Monterey County). Impact Monterey County had been working as a broad coalition on a community assessment and was transitioning to a network

[19] LiveStories is a data storytelling platform designed to make data engaging, easy to understand, and easy to share. The platform makes data available online in a visually appealing and highly interactive format. More information is available here: https://www.livestories.com/.

working on metrics, strategies, and objectives and the creation of a dashboard. They had had initial meetings and identified an initial set of metrics. We discussed the value-add of our work in Core Metrics and, after further discussion, thought that our work would complement their current activities. We did a crosswalk of the indicators they had identified with the Core Metrics and found several areas where the Core Metrics added important information to their process for selecting indicators. Moreover, they felt our convening process to not only identify measures but to drive action would be particularly useful. Monterey has modest urban areas plus rural areas. After further discussion, it seemed like our timelines would mesh and there was potential for good synergies.

California's San Joaquin Valley counties (Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, and Tulare) were particularly attractive because PHI's Cultiva La Salud is based in the San Joaquin Valley and focuses on advancing health equity using policy and environmental change approaches. Having a specific healthy equity focus was attractive because of the opportunity to not only to look at a geographic area, but also to further explore a specific population subgroup. We connected with many individuals to gain perspective and to narrow our choices, recognizing we wanted to work with a geographic area that had both urban and rural areas. We spoke with Genoveva Islas who is a PHI employee and directs Cultiva La Salud and works closely with county governments as well as community organizations and safety net providers. Her program is deeply embedded and trusted within the Latino community and has a long track record of successful projects. The focus on the Latino population presented both a data challenge as well as a great opportunity. The program was eager to use data-driven decision making and welcomed a set of locally specific and credible indicators. Although the program is based in California's San Joaquin Valley, a region of eight counties, for demonstration purposes we recognized that a single county would be both more feasible and have greater likelihood of influencing decision-making. In partnership with Ms. Islas, we selected Fresno County, which includes a sizable urban area as well as extensive rural areas, as the best site for this work.

## Interviews and surveys with stakeholders in each community

We identified stakeholders in each community under the guidance of a community leader who was a champion for the Core Metrics work (G. Islas, K. Hanni). To gather stakeholder input, we used the following methods: key informant interviews, roundtable discussions, and online surveys. Stakeholders were diverse and included representatives from safety net systems including FQHCs, not-for-profit hospitals working on their Community Health Needs Assessments (CHNAs), county health departments working on their Community Health Assessments (CHAs) that are required for public health accreditation, not-for-profit organizations, and stakeholders in other sectors, such as education and housing. When possible, we met with existing groups of collaborators to enhance efficiency and the process. Prior to the stakeholder interviews, we shared the Core Metrics Overview document with them (Appendix 2).

### Monterey

Five key informant interviews were conducted using a semi-structured interview guide (Appendix 3) with stakeholders in Monterey County. These stakeholders represented a healthcare organization (n=2), the Department of Social Services (n=1), the Monterey County Office of Education (n=1), and the Monterey County Health Department (n=1). Common themes around barriers to using a shared measure set were: measures do not convey the whole picture (for example, the measures focus on the

big picture and not the details of the stakeholders' work, measures are not focused on upstream factors), how do the Core Metrics fit in with the measures my organization or agency is focused on, and not having access to the data. Common themes around opportunities to collaborate with others to use a shared measure set were: people like having a small set of core measures that could be used to drive action, community engagement could be employed to make this core measure set actionable, creating a data dashboard could be a symbol of a successful project together, and they relate to work they are already doing.

Fifteen stakeholders from Monterey completed an online survey (Appendix 4). When asked to identify the three most pressing health needs of their community, the most common responses were social determinants of health (e.g. housing, poverty, citizenship, transportation, safety), followed by healthcare (access to physical and mental healthcare, access to affordable care, access to culturally competent care), and health-related behaviors (nutrition, alcohol, drugs).

The Core Metrics' best current measures and related priority measures could provide data to inform most of these identified health needs. Stakeholders in Monterey reported that they would like to see the Core Metrics measures reported by geography (93%), race/ethnicity (73%), age (53%), and gender (33%). Reporting data by zip code was the most popular geographic level selected (43%), followed by census tract (36%) and city (14%). One participant explained, "Data that is disaggregated at the ZIP code level by demographics allows us to see where disparities exist and to work towards solving health problems in targeted ways."

All stakeholders who completed the online survey stated that "shared data in action" was important to them. Stakeholders mentioned four main themes related to how their community could use a shared measure set for improving community health. The most common answer was to move towards collective impact. One participant explained they would use a shared measure set "to ensure we are all working towards the same goal." Participants mentioned using shared measures to work in the areas of general health, well-being, and early childhood; to align the work of local non-profit organizations to address the biggest health needs and gaps in care; and to work together in the areas of health, safety, economic stability, and education. Stakeholders also mentioned wanting to use a shared measure set to design programs, set goals, and secure funding. For data to be actionable and useful in the work of the stakeholders, they mentioned the following themes: to engage with government (such as to provide input to general plans, housing plans, and economic development plans), direct limited resources, and to foster understanding across sectors (such as between business and healthcare).

**Fresno**

Because there were many concurrent data and health improvement planning activities already occurring in the county before the current project was initiated, several discussions were held to assure this project would enhance their current work. The local stakeholders agreed that they had an excess of indicators and would benefit from a smaller set focused on the Latino community. Members indicated that this set of Core Metrics could serve as the "lid on the top of their box," meaning it could serve as a parsimonious set of shared measures representing what they collectively cared about.

Sixteen stakeholders from Fresno completed an online survey (Appendix 4). When asked to identify the three most pressing health needs of their community, stakeholders most commonly listed healthcare (access to care, access to prescription drugs, culturally competent care, importance of

bilingual healthcare professionals, recruitment of individuals into the healthcare workforce), followed by social determinants of health (housing, poverty, education, civic engagement, transportation) and health-related behaviors (access to opportunities for physical activity, active transportation, green space). Two stakeholders also mentioned environmental exposures (pesticides, air pollution).

The Core Metrics' best current measures and related priority measures could provide data to inform most of these identified health needs. Stakeholders in Fresno reported that they would like to see the Core Metrics measures reported by geography (93%), race/ethnicity (69%), age (50%), and gender (44%). Reporting data by census tract was the most popular geographic level selected (47%), followed by zip code (33%).

All except one stakeholder who completed the online survey stated that "shared data in action" was important to them. Stakeholders mentioned five main themes related to how their community could use a shared measure set for improving community health. The most common answer was to move towards collective impact. One participant explained they would use a shared measure set so "actions can be taken toward a shared goal based on the same data." Participants mentioned using shared measures to bring together the work of physicians, advocates and private citizens; and for health, active lifestyle, environmentalists, and environmental justice advocates to work together. Stakeholders also mentioned using a shared measure set to inform decision makers, decide where to direct limited resources, conduct advocacy, and obtain grant funding.

Prior to the first convening, a lunch meeting was held to review the project's intent. Community stakeholders participated and discussed how the Core Metrics could be helpful in their community. The meeting ended by members indicating they would confer with their larger health improvement planning group to secure interest and commitment.

### Convening #1, August 2016- Meeting with community stakeholders to plan story content

The first convening with community stakeholders was designed to spur collective action among participants. The objectives for the first convening were to:

1. Understand Core Metrics: what they are and how they can help us make our community healthier,
2. Collectively explore how the preliminary set of Core Metrics can be used to set a course of action,
3. Identify any critical gaps the community sees in the measures themselves, and
4. Familiarize the community stakeholders with LiveStories and how that tool may serve them in driving action.

In addition to achieving the objectives, the additional goals for the first convening were: to review the project, discuss potential measures (including identifying high priority topics not included in the Core Metrics best current measure set to supplement and enhance the relevance and ownership of the final product and to familiarize them with the custom built websites), and consider how the information can be presented in forms and formats that are most conducive to their use in collaboration, engagement, and planning.

The community champions (G. Islas, K. Hanni) set the tone for the convening, explained to the participants why they invited them to the convening, and explained their vision for the work and hopes for the day. We then used a World Cafe format where rotating small groups of four explored questions presented to them. It is a methodology that assures broad engagement of participants and helps to surface themes, patterns and new ideas. It also helps to surface collective wisdom in support of moving towards collective action. The World Cafe allowed each group of participants to prioritize their topics of interest and any additional topics to add to the Core Metrics best current measures. During the World Cafe, we asked the groups to consider the following questions:

- How might the Core Metrics + LiveStories help us make our community healthier?
- Are there any critical gaps in the measures themselves?
- We want to get to a single issue we are going to be working on. If you were to drive a course of action with these tools, where would you focus your attention?
- What story do you want to tell?

**Fresno results**

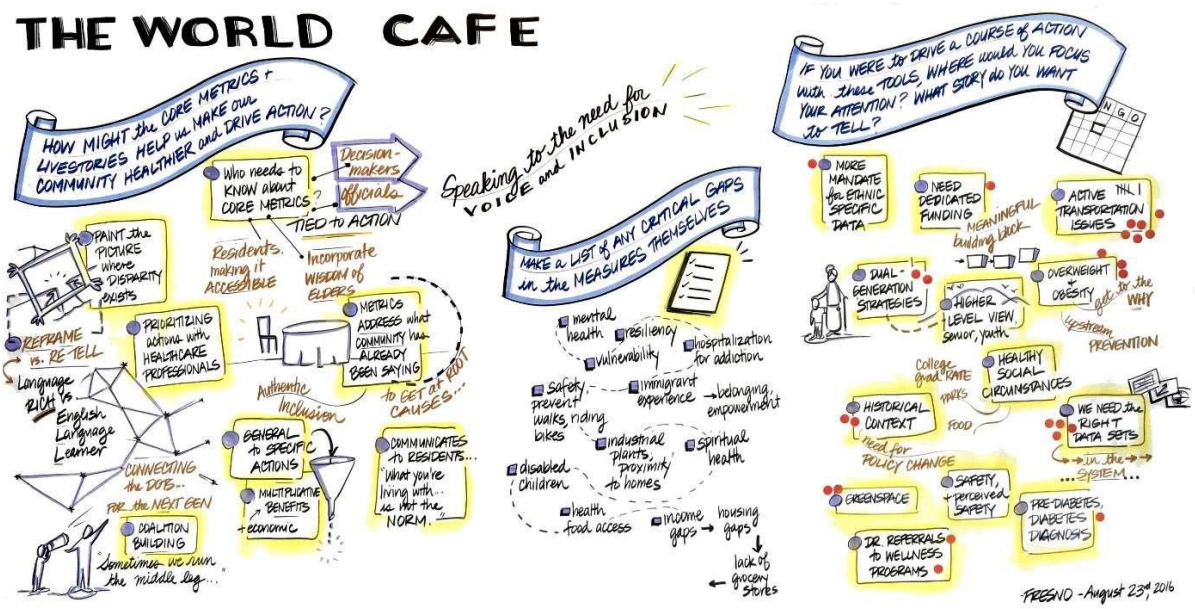
Convening #1 was held in Fresno, CA on August 23, 2016. Twenty-two stakeholders attended this convening. Details about this convening (agenda, detailed notes, graphic recordings) are included in Appendix 5.

An overarching theme that emerged during Convening #1 in Fresno County was that the Core Metrics were an opportunity to offer the Latino community a greater voice and inclusion in conversations around health, including social determinants of health. Additionally, four main findings emerged during Convening #1's World Cafe (Figure 1, Table 1.1):

1. The Core Metrics should show where disparities/inequities exist,
2. Many people need to know about Core Metrics, including residents, elders, decision-makers/officials,
3. The Core Metrics will likely demonstrate what the community has already been saying, and
4. Gaps exist in the Core Metrics primary measure set, and these gaps are primarily related to social determinants of health.

Then, various issues were raised for consideration in future Core Metrics data compilation and storytelling components of the project (Table 1.2). Convening #1 concluded in Fresno with a vote on which issue should be added as a supplemental issue to the Core Metrics best current measure set. *Active transportation* received the most votes (n=6), so the group decided that this issue would be chosen to add as a supplemental indicator for the Core Metrics best current measure set in the Fresno community.

**Figure 1. Findings from World Café**
Setting: Fresno Convening #1




| **Table 1.1 Critical gaps in the Core Metrics measures**<br>Setting: Fresno Convening #1 | |
|---|---|
| • Mental health | • Children with disabilities |
| • Resiliency | • Healthy food access |
| • Hospitalization for addiction | • Income gaps |
| • Immigrant experience (for example, belonging, empowerment) | • Housing gaps |
| • Spiritual health | • Vulnerability |
| • Safety (walking, biking) | |

| **Table 1.2 If you were to drive a course of action with these tools, where would you focus your attention? What story do you want to tell?**<br>Setting: Fresno Convening #1 | |
|---|---|
| **Issue** | **Votes*** |
| Active transportation issues (walking, biking) | 6 |
| We need better datasets (for example, more data reported by ethnicity) | 4 |

| | |
|---|---|
| Overweight and obesity root causes | 3 |
| Historical context (for example, differences in infrastructure investment) | 2 |
| Access to green space | 2 |
| Dual-generation strategies | 2 |
| Physician referrals to wellness programs | 2 |
| Pre-diabetes | 1 |
| Higher level view (for seniors, youth) | 0 |
| Healthy social circumstances (e.g. college graduation rate, presence of parks) | 0 |
| Safety, perceived safety | 0 |

*0 votes means the issue was mentioned during group discussion, but no one voted for it.

**Monterey results**
Convening #1 was held in Monterey, CA on August 22, 2016. Twelve stakeholders attended this convening. Details about this convening are included in Appendix 6.

Four main findings emerged during Convening #1's World Cafe (Table 1.3):

1. Need more information about the Core Metrics and how they are defined/operationalized,
2. The Core Metrics can help us work together across organizations by providing a shared purpose,
3. Gaps exist in the Healthy People primary measure set because the set did not include all indicators that were important to the community, and
4. Core Metrics provides structure against which to evaluate other indicator sets that the County is currently using.

Gaps were identified during Monterey's Convening #1 and reported in Table 1.4. The gaps were mostly in the Healthy People/population health domain. Participants also discussed how the Core Metrics could provide structure for Impact Monterey (a major local collaborative initiative see http://www.impactmontereycounty.org/) if appropriate steps were taken to compare the measures in each set. At the end of Monterey's Convening #1, participants discussed various ways to move forward with the Core Metrics work and how it could complement the work that was already occurring in the County and particularly with Impact Monterey (Table 1.5). The group reached consensus that the Core Metrics team would add *Safety-related measures* as a supplemental issue to the Core Metrics best current measure set for Monterey County.

| **Table 1.3 What are you working on related to Impact Monterey County's 4 Priority Areas?**<br>Setting: Monterey Convening #1 | |
|---|---|
| Themes | Examples |
| Need more information | Core measures apply generally but need to know how to apply them |
| | Core Metrics indicators are overarching, but there may be other important indicators |
| | Some measures, e.g., Engagement, could be defined in many ways and Core Metrics could standardize definitions |
| Working together | Core measures - conversation starter; work together as group |
| | Common things we can act on |
| | Could help set up community indicators - 4 domains, standardized language, 4 priority measures not health focused |
| | Shared language - easily aggregate |
| Other comments | Need for localized and industry data |
| | Communicate value of metrics - not large report format |
| | Important economic indicators are not present in Core Metrics |

| **Table 1.4 What, if any, gaps do you see in the measure set? What's missing?**<br>Setting: Monterey Convening #1 | |
|---|---|
| **Theme** | **Example** |
| Healthy People/ Population Health | Mental health measures |
| | Income |
| | Housing / Security |
| | Food security / Food desert |
| | Built environment measures |
| | Social emotional health (education) |
| | Add death rate in county |
| | Safety |
| | Early childhood is not sufficiently covered |
| | Lifelong learning |
| Care Quality | Person-centered care - how can they articulate that if they don't know what they are entitled to in their benefits |
| | Gap between Natividad and Chomp data (two local hospitals) |
| Engaged People | Engaged people - too vague- is there a better measure? |
| | Business, Economy, Self-sufficiency |
| Provide structure for Impact Monterey | Core metrics could help support Impact Monterey and the crosswalk |
| | Clarity of measures / definition |
| | Need to create crosswalk with Core Metrics |
| | Impact Monterey is not 100% aligned with Core Metrics. There is language discrepancy between Core Metrics and priority areas of Impact Monterey. |
| Other | Business engagement |

| **Table 1.5 Given all that you have heard today, how might we move forward to spur collective action with this shared knowledge base? What could we do together?** Setting: Monterey Convening #1 | |
|---|---|
| **Theme** | **Examples** |
| Healthy People/ Population Health | Mental health |
| | Early childhood |
| Provides structure for Impact Monterey | Use Core Metrics as framework - agree on one indicator |
| | Frame Impact Monterey with Core Metrics story |
| Shared purpose | Barriers - shared language, need to do something |
| | Shared understanding of problem |
| Other | Safety (holistic approach to engage in community) |
| | Process - human centered design (each group select priority and progress prototype / process, approach) |

## Data Compilation

Based on the information gleaned at the first convening in each county, we compiled the data for the LiveStories sites as described below. To avoid duplication of efforts and leverage existing data, we created crosswalks for each site (Monterey, Fresno) by comparing the Core Metrics to existing indicator sets in use by each community. We compared the measure set Monterey County was planning to use[20] with the Core Metrics and found three common indicators. We compared Fresno County's Health Status Profile for 2016 (30 indicators) to the Core Metrics measure set and found four common indicators in both sets of measures. For Fresno only, we also compared the Core Metrics to data used in Fresno County's most current Community Health Needs Assessment (CHNA).

After examining the measure sets currently in use in each site, we examined existing data sources and capitalized on existing data as much as possible, focusing our attention on the best current measures and only incorporating the related priority measures if they were of particular interest to the individual communities. Additionally, we worked with each community to select one additional high-priority topic to include in the Core Metrics for that community.

We used the following criteria to gather and report data:

- Publicly accessible data from reports (e.g., healthcare acquired infections [HAI]) or dashboard websites (e.g. California Health Interview Survey [AskCHIS], County Health Rankings [CHR], Dartmouth Atlas).
- Present data that are statistically stable.
- Compare to state and national data when possible.
- Drill down by geography, race/ethnicity, age, and gender when data are available and statistically stable.
- Get data from Health Department, CHNA, or other indicator projects when available. Note: We did not need these data. By using existing reports, users could know that statistics were reliable and stable.
- Present statistics to community stakeholders before finalizing them to be certain they accurately represent the community. For example, there is a problem with using voter turnout statistics for community engagement due to the high proportion of residents not having the right to vote (e.g., non-citizens).

We were able to find data to report on 14 of the 15 Core Metrics indicators at the county level, and five of the 15 at the sub-county level (Table 3). Of the 14 Core Metrics we found, 12 were identical to those included in the national IOM report and two were included as proxies when the national measures did not exist at the local level (i.e., health literacy, social support). All of the measures in the Healthy People and Care Quality domains were available at the county level. Three of the six measures in the Healthy People domain were available at the sub-county level. Two of the five measures in the Care Quality domain were available at the sub-county level. One of the two measures in the Care Cost domain was available at the county level. The other (high spending relative to income) was not available. None of the two recommended primary measures in the Engaged People domain were available at the county or the state level. We substituted other measures for these (English language literacy, voter participation). Many of our community stakeholders were very interested in data on social support and health literacy, but they were not available.

[20] http://www.livewellsd.org/content/dam/livewell/indicators/Framework%20UPDATED%2010-23-15.pdf

| Table 3 Best Current Measure Core Metrics sources at the National, State, County, and Sub-County Levels in Demonstration Communities in public-use reports | | | | |
|---|---|---|---|---|
| | National source | California source | Pilot project county source | Pilot project sub-county source |
| **Healthy People** | | | | |
| Self-reported health | CDC NHIS | CHIS | CHIS | CHISNE (zip code) |
| Body mass index | CDC NHANES | CHIS | CHIS | CHISNE (zip code) |
| Life expectancy | CDC VSS | IHME | IHME | Measure of America (zip code) |
| High school graduation rate | DOEd NCES | CDE | CDE | CDE (school) |
| Addiction death rate | SG and VSS | CHR from CDC VSS | CHR from CDC VSS | Not available |
| Teen pregnancy | CDC VSS | CHR from CDC VSS | CHR from CDC VSS | Not available |
| **Care Quality** | | | | |
| Childhood immunization rates | CDC NIS | CDPH | CDPH | CDPH (school) |
| Unmet care need | CDC NHIS | CAHPS | CAHPS | CAHPS (medical group) |
| Hospital-acquired infection rate | CDC HAI and AHRQ HCUP | CDPH | CDPH | CDPH (hospital) |
| Preventable hospitalization rate | AHRQ HCUP | Dartmouth Atlas | Dartmouth Atlas | Not available |
| Patient-clinician communication | CAHPS | CAHPS | CAHPS | CAHPS (medical group) |
| **Care Cost** | | | | |
| High spending relative to income | CF | Not available | Not available | Not available |
| Per capita expenditures on healthcare | CMS | CA DHCS | CA DHCS | Not available |
| **Engaged People** | | | | |
| Health literacy | DOEd NCES | US Census | US Census | Not available |
| Social support | CDC BRFSS | CHIS | CHIS | Not available |

**Abbreviations in Table 3:**
ACS American Community Survey
AHRQ Agency for Healthcare Research and Quality
BRFSS Behavioral Risk Factor Surveillance System
CA DHCS California Department of Health Care Services
CAHPS Consumer Assessment of Healthcare Providers and Systems
CDC HAI Centers for Disease Control and Prevention Healthcare Associated Infection Prevalence Report

CDC VSS Centers for Disease Control and Prevention Vital Statistics System
CDE California Department of Education
CDPH California Department of Public Health
CF The Commonwealth Fund
CHIS California Health Interview Survey
CHISNE California Health Interview Survey - Neighborhood Edition
CHR County Health Rankings
CMS Centers for Medicare and Medicaid Services
DOEd NCES Department of Education National Center for Education Statistics
HCO Health care organization
HCUP Agency for Healthcare Research and Quality Healthcare Cost and Utilization Project
IHME Institute for Health, Metrics, and Evaluation
NHANES National Health and Nutrition Examination Survey
NHIS National Health Interview Survey
NIS National Immunization Survey
SG Surgeon General
TCOC & RU Total cost of care and resource use

## Building Core Metrics Websites

Between Convening #1 and Convening #2, the PHI team built custom websites featuring the Core Metrics indicators using LiveStories, a web-based data storytelling platform that combines images, charts, maps, videos, and rich text to tell a story. We built four online "Vital Signs report card" interactive websites, two each (one in English and one in Spanish) for Fresno and Monterey communities. These websites displayed the Core Metrics indicators for the demonstration communities (county and sub-county data) compared to state and national data[21]. Each website was designed to be a sustainable reporting tool that each community can update over time to assess progress. Additional websites were built to share additional indicators selected by consensus during Convening #1 (active transportation in Fresno[22], safety in Monterey[23]). The additional indicators were chosen because they were important for current work in each community-based site. In addition to data, the report included photos provided by our partners in each community and text written by our partners to describe their current efforts, tell their story in their own words, and indicate the future direction of their work.

Our decision to use LiveStories for creating the custom websites was informed by neuroscience. When one reads or hears facts and figures, two regions of the brain become active - the regions that govern language processing and language comprehension. When one reads, hears, or views a story, there is neurosynaptic activity taking place. This is because the neural structures that process sensory information - sounds, movement, colors and shapes - also become active. This is important because when we want to make meaning with and from our data, using descriptive elements can help readers' brains to make and retain meaning. We remember stories longer and better than we remember facts and figures. In fact, stories can actually increase our ability to retain facts and figures.[24]

Because of the value of storytelling, we decided to use LiveStories so make the report more than just a data presentation. We prepared data files with the Core Metrics national, state, county, and sub-county data and additional indicators (active transportation in Fresno, safety in Monterey) and imported them into LiveStories. Then, we used these files to create charts that could be placed inside online story websites. The charts and graphs were supplemented with photos and text to tell the full story of the indicators in each community. Our goal was to elevate the final product into something more interactive and visually appealing than just a data dashboard.

During our work with both communities, we found that it was important to both of them to have the websites built in English and Spanish, since both communities have high numbers of monolingual Spanish speakers. Furthermore, Monterey County Health Department was being asked by its senior leadership to produce more materials in Spanish, and Cultiva la Salud, our partner in Fresno, has a focus of working to improve health in the Latino community. Therefore,

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[21] Fresno Core Metrics: https://insight.livestories.com/s/v2/fresno-county-core-metrics-overview/18574b4e-a48c-4537-adb5-3dae7b63f59f
Monterey Core Metrics: https://insight.livestories.com/s/v2/monterey-county-core-metrics-overview/c3f8ed0a-87ec-4267-92fd-6e9cb4a56b8b/

[22] Fresno Active Transportation: https://insight.livestories.com/s/v2/fresno-active-transportation-overview/d3571c3e-a515-4ff8-9193-447a05dd8bc4/

[23] Monterey Safety and Health: https://insight.livestories.com/s/v2/safety-and-health-in-monterey/d3947d2c-6804-4438-879c-17677d5d904d/

[24] Monarth, H.(2014, Mar 11). The Irresistible Power of Storytelling as a Strategic Business Tool. *Harvard Business Review.* Retrieved from: https://hbr.org/2014/03/the-irresistible-power-of-storytelling-as-a-strategic-business-tool

after building the websites in English, we translated them into Spanish. All translations were done by native Spanish speakers who are fluent in English and Spanish and are highly proficient in public health and healthcare terminology. In addition, every translation was reviewed by a staff member who has a certificate in Spanish translation from the University of California, San Diego, and the bilingual epidemiologist who built the sites.

The LiveStories platform has limitations that impacted how we could display the data. For example, the platform does not allow confidence intervals to be displayed in its charts. Some of the Core Metrics indicators had confidence intervals that were very wide. Fresno County wanted to display obesity prevalence among Asians, and the only public-use data available was the California Health Interview Survey. But the confidence interval for obesity prevalence among Asians was wide and considered unreliable, per the California Health Interview Survey guidelines. Therefore, we chose not to display any data deemed unreliable due to the size of the confidence interval, which we explained in the Technical Notes sections of the online stories. While some websites, such as AskCHIS, display the confidence intervals to indicate the point estimates are reliable, the websites we built with LiveStories did not allow us to do so, so we had to be selective about which statistics to present.

After the second convening, the PHI team made additional changes to the LiveStories sites so they were meaningful and useful to the community. Mostly, this meant revising text regarding recommendations for future action to make sure it accurately reflected what community-based groups were committed to acting on. Then, all the content of the LiveStories sites was transferred to a representative from each of the community-based demonstration sites. This was possible because one site decided to purchase a LiveStories license for future work after participating in the project, and the other site had an existing LiveStories license.

## Convening #2, December 2016 - Meeting with community stakeholders to present draft stories

A second, final convening was held to review the Core Metrics displayed in interactive, storytelling data visualization websites in LiveStories, present the results, and discuss possible actions moving forward. The objectives for the second convening were to:

1. Leave the community stakeholders with access to the complete Core Metrics measure set for their county and access to LiveStories so they could update and adapt the interactive data visualization when needed for their continued use into the future as an advocacy and tracking tool.
2. Present the Core Metrics set in the LiveStories Platform and explore how they could use it
3. Discuss and understand how the project process has (or has not) been useful for the community stakeholders' current and future work.
4. Explore next steps around the selected "additional measure" LiveStories site and identify champions to move the work forward (active transportation in Fresno and safety in Monterey).
5. Identify how this process has been useful and could be improved for replication in other communities.

Then we again used a World Cafe format to harness the collective wisdom of the group and asked question in small groups of four, rotating to new groups after each question and reporting out after each round. The questions explored were:

1. How might we use these tools (Core Metrics and LiveStories) for advocacy/driving change?
2. How might we work together with this tool to move actions forward? How can we maintain it in the future?
3. Commitments/ Next Steps

**Fresno results**

Convening #2 was held in Fresno, CA on December 7, 2016. Eleven stakeholders attended this convening. Details about this convening are included in Appendix 7.

At Convening #2 in Fresno, preliminary versions of the LiveStories sites[25] were presented to the participants. Participants had a chance to share their impressions of the sites and suggestions for improvement. Then, the facilitators led the participants in a World Cafe and group discussion of how to use the Core Metrics work in Fresno County.

Three main themes emerged during Convening #2's World Cafe in Fresno County (Table 2.1):

1. Involve the community
2. Use the Core Metrics and LiveStories sites to secure funding to improve public health and the social determinants of health
3. People and efforts should be organized to drive action using the Core Metrics and LiveStories.

At the end of the convening, the participants committed to use the Core Metrics LiveStories

[25] https://insight.livestories.com/s/v2/fresno-county-core-metrics-overview/18574b4e-a48c-4537-adb5-3dae7b63f59f/
https://insight.livestories.com/s/v2/fresno-active-transportation-overview/d3571c3e-a515-4ff8-9193-447a05dd8bc4/

sites to accomplish the following (Table 2.2 and Table 2.3):

1. Gather and share more data by asking government officials to share their data and by collecting additional needed data using teams of volunteers.
2. Build capacity and leadership.
3. Create economic opportunities.

**Table 2.1 How might we use these tools (Core Metrics and LiveStories) for advocacy/driving change?**
Setting: Fresno Convening #2

| Theme | Example |
|---|---|
| Involve the community | Invite the community in to draft the messaging (opportunities for education and advocacy) |
| | Use with residents and elected officials to design a custom data dashboard that uses plain language and is actionable |
| Secure funding | Data can demonstrate inequities about how funding decisions are made |
| | Provides data on Latinos to drive resources where most needed and investments can be made (equity versus deficit) |
| | Provides data for concerted applications for funding to support infrastructure |
| Consider for future use | Messaging the issue (should be trustworthy, use plain language) |
| | Use of analogies (such as ADA example – ADA requirements benefit all people who live in the communities, not just people with disabilities) |

| **Table 2.2 How might we work together with this tool to move actions forward? How can we maintain it in the future?**<br>Setting: Fresno Convening #2 | |
|---|---|
| **Theme** | **Example** |
| Organize people/efforts | Identify a work group to carry the work forward |
| | Suggest a volunteer team to track and collect data. |
| | Asset map of members who are working on this issue |
| | Bring regional LHJs together (Central Valley Health Policy, Partnership for San Joaquin Valley) |
| | Collect count data to provide data for applications to improve active transportation |
| | Present LiveStories websites to these groups |

| **Table 2.3 Commitments/Next Steps**<br>Setting: Fresno Convening #2 | |
|---|---|
| **Theme** | **Example** |
| Gather and share more data | Neighborhood investments |
| | Animal control (loose animals make active transportation unsafe) |
| | Track data over time (especially on neighborhood investments) to monitor changes |
| Build capacity and leadership around active transportation | Bike kitchens – train youth and adults to repair bikes |
| | Create a social equity task force model from Council of Governments Environmental Justice Task Force |
| Create economic opportunities | Microenterprise – create a demand for services and businesses |
| | Bring together neighborhood investors, identify ways to work better together |

**Monterey results**

Convening #2 was held in Monterey, CA on December 8, 2016. Fifteen stakeholders attended this convening. Details about this convening are included in Appendix 8.

At Convening #2 in Monterey, preliminary versions of the LiveStories sites[26] were presented to the participants. Participants had a chance to share their impressions of the sites and suggestions for improvement. Then, the facilitators led the participants in a World Cafe and group discussion of how to move the Core Metrics work forward in Monterey County.

[26] https://insight.livestories.com/s/v2/monterey-county-core-metrics-overview/c3f8ed0a-87ec-4267-92fd-6e9cb4a56b8b/
https://insight.livestories.com/s/v2/safety-and-health-in-monterey/d3947d2c-6804-4438-879c-17677d5d904d/

Three main themes emerged during Convening #2's World Cafe in Monterey County (Table 2.4 and Table 2.5):

1. Growing together as we work together
2. Participating in mutually reinforcing activities
3. The Core Metrics and LiveStories websites makes it easier for us to invite the media into our work.

In addition, convening participants voted on the Core Metrics that were most important for their community. During the convening, opportunities were identified that could drive the Core Metrics work (so-called "champion initiatives") in the focus areas of Impact Monterey County: economic self-sufficiency, education, health, and safety.

**Table 2.4 What is currently happening around indicator projects in Monterey County?**
Setting: Monterey Convening #2

| **Theme** | **Example** |
|---|---|
| Growing together as we work together | Building the ship as we go |
| | Choosing indicators to work towards |
| | We are on the same path together |
| Mutually reinforcing activities | Not having capacity in the city, but in the county |
| | Having deeper data than ever before |
| | It's a long-term outcome, not "threatening my program" |

**Table 2.5 How might we use these tools (Core Metrics and LiveStories) to drive action in Monterey?**
Setting: Monterey Convening #2

| **Theme** | **Example** |
|---|---|
| To invite the media into our work | Human interest stories don't get clicks |
| | PSAs, constant branding |
| | Newsletters, social media, photos |
| | Drive traffic to our websites |
| One call to action per story | |
| Bring together coalitions | |
| A database hub | |

## Results from post convening surveys

We collected surveys from the participants at Convening #2 with open-ended questions (n=10 in Monterey, n=2 in Fresno). These surveys aimed to gather information about the following topics:

1. What do you think is the utility of this work (Core Metrics and LiveStories for driving action in community) in other locations?
2. What was useful?
3. What did you like about these engagements and our exploration around Core Metrics and LiveStories?
4. What was not useful? What could be improved and how?

Participants expressed appreciation for the group process that was highly participatory and fostered peer-to-peer learning, collaboration with other organizations, and deciding to share a

common source of data. One participant stated that: “By discussing these topics in one collective place we can try to frame the discussion and possible action as a collaboration.” Another stated that the Core Metrics project was “helpful in connecting organizations and creating a shared vision and mission.” Another participant stated that the Core Metrics were “a common source of data for policy makers, media, collaboratives and partner agencies.” Another participant also reported learning that “we all share common struggles [across organizations and agencies]” after participating in the Core Metrics project. The logistics of the convening may have been partly responsible for fostering this participatory environment because the rooms were set up during the convenings to have participants sit in a circle for some of the event, which fostered dialogue among participants.

Participants reported that they liked the websites built using LiveStories. One participant said that the websites were “a great way to see a variety of data in a central location.” Another noted that LiveStories allows “a lot of valuable data [to be] in one place- great for organizations, agencies and researchers.” Although they liked LiveStories, some participants felt the LiveStories aspect of the Core Metrics project could be improved. For example, the storytelling piece of the LiveStories sites we built for the Core Metrics project could be improved by engaging more with the community members to draft the story text and decide on how to frame the issues. Also, one participant stated that the websites “could be ineffective if it just sits online,” and the challenge was to now disseminate the websites to others and increase traffic to the websites. Our community champions (G. Islas, K. Hanni) intend to distribute the websites widely within their communities. We plan to contact both of them in three months after the sites first are first disseminated as part of a follow-up survey.

Participants were thrilled with the use of a graphic recorder (used at Convening #1 in Fresno and Convening #2 in Monterey). For example, participants stated that the graphic recorder’s story boards were “amazing.” One participant explained that the graphic recorder’s “visual boards and live drawings made a huge impact and a full picture view of topics discussed.” Another participant noted that “the graphic recorder was mind-blowing! [She was] very well organized and great use of time.” Images from the graphic recorder are available in Appendices 5 and 6.

# Overall Key Findings/Lessons Learned

## Community Engagement

Community engagement is critical to determine how to share data that can inform current work occurring in communities. Participants and the communities in our project found the community engagement process very beneficial, and it stimulated conversations that needed to happen. The community defined for themselves actionable metrics, and we helped them put in place a process to set goals and track progress that engaged them for long-term success. From our perspective, it is clear that the Core Metrics indicator set must be tailored for each community in order for it to be meaningful for that community.

When our work began, there were extensive activities already directed towards improving social determinants of health in each of the pilot project communities. They fit well with the Core Metrics, because the Core Metrics measure set includes social determinants of health. The community groups we worked with were also active in working towards health equity. We found that the communities believed the Core Metrics could drive further data analysis to support

equity issues. In addition, our work informed community groups of the criteria used to define and select the Core Metrics[27], which enhanced credibility to these groups who later considered adopting it for their indicator selection processes. It was during the community engagement process that our implementation team learned that both community stakeholder groups believed it was critical to build all interactive data visualization sites in English as well as Spanish.

Challenges with the community engagement process were that it was difficult to gather people and have the community champion (G. Islas, K. Hanni) lead this effort because they have so many other commitments. The community engagement process was highly resource intensive and required many more hours of staff time than originally planned.

## Data Compilation

It is possible to compile the Core Metrics data at the local level and compare them to state and national measures. One of the major challenges with implementing the measures in the Vital Signs report was the lack of specificity of the recommendations. Recommended measures are more "topics" than actual measures. The data presented in the Vital Signs report are national which are of only marginal use to local communities. Thus, it was important to identify the information that can be used at the local level, and, more than that, to the extent possible, use measures that have the same specifications in all communities. However, one challenge was that sometimes, national measures (such as health literacy) were not available at the local level, so we used proxies (English language literacy, voter turnout). Through the data compilation process, we determined that most of the Best Current Measures in the Vital Signs report were available at the county level (12 of 15 measures), and some were available at the sub-county level (five of 15 measures). We also found two measures that we used as proxies for three of the 15 we could not identify at the county level. Data on health literacy were not available in the pilot project communities, so we reported data on English language proficiency (as a proxy for literacy in the US) and voter turnout (as a proxy for civic engagement). Similarly, data on social support were not available in the pilot project communities, so we reported data on meeting to discuss community issues. The only Best Current Measure we could not directly address was high spending on health relative to income.

## Building Core Metrics websites

Communities reported that they planned to use LiveStories for policy advocacy to drive change (share with city officials, stakeholders); track indicators over time to report to stakeholders (government officials, advocates, community members); make data accessible for community-based groups to drive policy change or apply for grants; and incorporate data, photos, or text from LiveStories into other information platforms. One of the pilot project communities decided to adopt LiveStories after our pilot project was complete. Another community already had a LiveStories account but was uncertain if they wanted to continue using it after our project ended.[28] To our knowledge, both communities will continue to use the Core Metrics websites to promote their work and drive action to improve public health. Prior to the end of our project, our team trained representatives from both pilot project sites on how to use LiveStories, including

[27] Criteria can be found on page 14 of the Vital Signs report in Box S-2: Criteria for Core Measure Development.

[28] The websites our team built using LiveStories will be available permanently on the Internet via the URLs listed previously in the report. However, to update them, a LiveStories account is required. So, the websites can be shared and used without an account, but not updated.

how to update content on the sites (photos, text, videos, and data).

Though compiling the 15 Core Metrics indicators for each site required up-front investment, this allowed us to become knowledgeable of the data sources that could be used to build similar websites using LiveStories in all California counties. To build additional websites to display the Core Metrics for each California county would take relatively fewer hours overall than it took to build the Core Metrics LiveStories sites for each pilot project site. These county sites could be built in a way that would allow customization by county, if the county desired, and only include community engagement if the county requested it.

## Recommendations for replication in other communities

After implementing the Core Metrics in two pilot project communities, we developed recommendations for replication in other communities.

- **To facilitate the use in other communities, the Core Metrics indicators should be made available at the county level in an online platform that is publicly accessible.** The LiveStories HealthData+ platform can be used to provide an attractive interface for users. This is certainly feasible in California, but an assessment of the availability of those metrics in other states would be needed on a case-by-case basis. Next steps for PHI include making the Core Metrics data available on a single platform for every county in California and to encourage use of that platform to develop population health initiatives. These sites could be one way to provide a science-base to plan and evaluate public health programs and policies in communities, such as the Accountable Communities for Health initiative ramping up in the state. Also, once the data have been displayed, it may be easier to engage communities and peak interest.

- **The content of the stories should be written by community members.** This story should be developed by community members. Our implementation team provided the data for the story, but it was the responsibility of each community to provide the story content to accompany the data in custom websites. Our team recommends adding an additional in-person workshop to prepare content for these websites. This recommendation was also mentioned by convening participants in the post convening survey. Champions and community members should be invited and a facilitator should gather story content during this workshop. The workshop could be designed so that the PHI implementation team can better understand the community's perspective. For example, the workshop could bring in champions and community members, hear their stories, allow the implementation team to reflect on them, and write from there.

- **Use a community engagement process to increase familiarity with the Core Metrics while fostering collaboration and common understanding between the members of the Core Metrics implementation team** (stakeholders, facilitators, data analysts, and project leadership). Community engagement also allows various stakeholders (such as community members, representatives from community-based organizations, and representatives from government agencies and healthcare organizations) to come to the table and make sure all those who should be present, are present (as recommended by a convening participant). This also provides an opportunity to analyze the unique assets each stakeholder brings to the group and would allow the creation of an asset map (as recommended by a convening participant). The community engagement process can be one important way to identify key opportunities for driving action using the Core Metrics. For

example, the engagement process in our pilot project augmented, but did not supplant, existing indicators projects in the communities where we worked. Additionally, the community engagement process can provide context that can be used to create the "story" behind the Core Metrics indicator data. A primary champion was needed to connect our implementation team to stakeholder and other community members. This champion could be a government official, community leader, or healthcare business leader. The addition of a graphic recorder to our implementation team helped us leave a permanent, attractive, engaging, and useful record of the community engagement deliberations that stakeholders could use to further their Core Metrics work (see graphic recording images in Appendix 5 and 8). In addition, future projects should consider engaging the media to invite them in to learn more about this work (as recommended by a convening participant).

- **The community process was valuable but resource intensive.** For this pilot project, we offered $25,000 as part of a deliverables-based contract to each community-based site to participate in the project, but still struggled with having the community leaders participate in the project (Appendix 9). For this reason, we include three recommendations to make the community engagement process less resource-intensive.
    - First, using an application process for sites to demonstrate their interest and commitment to implementing the Core Metrics would help us evaluate how ready a site is to participate and conduct the tasks expected of them in the project. Our experience was that our sites were not as ready to participate in the project as we expected them to be, and the PHI team and local champions spent a great deal of staff time to motivate the community leaders to participate. The community leaders were very busy people with many competing demands, and in our experience, developing a collaborative relationship can differ substantially with each individual. Also our project was organized so our team members were like interlopers into ongoing processes at each site. Hence, the need for pulling rather than pushing these activities at the community level. We feel that adding an application process to the project would create additional accountability as well as allow our implementation team at PHI the opportunity to better assess site readiness.
    - Second, the community based leader should co-host the convenings. For example, K. Hanni co-hosted Convening #2 in Monterey, which demonstrated she had ownership and investment in the project. As a general recommendation, instead of the PHI implementation team hosting each convening, the community leader should co-host each convening, and that would be listed in the Scope of Work.
    - Third, a design team concept could be introduced to the project. The design team could be composed of a small group (about five) of engaged local leaders who provide local context that the implementation team staff do not have, and also have enough pull to engage the community. This would reduce the burden of engagement on just one leader, and would spread out the burden to multiple people. To make sure the project moves forward on schedule, a local project coordinator could be designated and devoted to this task. If we had more diverse people on the team helping to make it happen, not just depending on one person's social capital and one person's perspective, the design team could be a successful way to engage community.

- **Future projects should consider facilitating peer-to-peer learning across multiple sites.** If the project is conducted with multiple sites, opportunities for peer-to-peer learning can be designed as part of the project so that the sites may learn from one another. We believe if the community leaders had been in contact with each other, valuable peer-to-peer learning could occur. Because our leaders were from different types of organizations (a

community-based organization and a health department), the learning may have been even more valuable than bringing together leaders from similar organizations.

- **The indicators selected by the community as priorities (*Active Transportation, Safety)* were not part of the Core Metrics primary measures.** The Core Metrics helped our community-based sites to focus on one specific topic (e.g. safety, active transportation), and due to the strong community engagement component of our project, we assisted the sites so they could implement the project and take ownership. Notably, however, the community-based sites selected topics that were not part of the Core Metrics Best Current Measures set. However, the additional topics were related to the Related Priority Measures (safety and violence and injury prevention, active transportation and activity levels). If we had worked with sites from the clinical care system, we may have found that the Core Metrics Best Current Measure set was more relevant to those communities.

Many indicator sets exist; no matter which indicator set the community chooses to adopt (e.g. County Health Rankings, 500 Cities, America's Health Rankings, Core Metrics), and these indicator sets can help communities compile and present data to drive action in their communities. Virtually every community in the United States has at least one indicator project underway. Our project's findings demonstrate that the Core Metrics can fit in with existing efforts (such as with the Community Health Needs Assessment in Fresno County, or Impact Monterey County), and the Core Metrics can be adapted so they are meaningful for communities and provide indicators that are important for their work. The question we are left with is: do the Core Metrics add value to existing data projects? We observed in this pilot project that they do. In Monterey, they loaned credibility to a plethora of existing indicator projects that were being conducted simultaneously but not progressing. In Fresno, they provided data to a community-based group that did not have access to the health data they craved for use in their advocacy efforts.

# Epilogue

Our pilot project suggests that the Core Metrics may be a useful indicator set for local jurisdictions to adopt and track. Our work with two California communities found that the Core Metrics can add value to existing data projects and lend credibility to select indicators. Our project is distinguished from other health indicator projects because of its focus on community engagement and sharing the indicators via custom built websites focused on combining data with storytelling.

There is statewide and national interest in expanding our work with the Core Metrics. Future opportunities may arise to develop custom websites that combine data with storytelling for each county in California and to pilot additional sites outside of California. These opportunities include work with the National Academies of Science, Engineering, and Medicine, and the Accountable Communities for Heath. It is becoming increasingly recognized that sharing data in ways that many people, not only those with expertise in data interpretation, can understand and find meaning is a critical way to advance public health. Sharing the Core Metrics in a way that is easy to understand via custom websites, and designing the indicator set to include input from the community so the metrics are accepted is important and critical for the community's health priorities.

# Appendices

## Appendix 1: IRB Approval

May 2, 2016

Steven Teutsch, MD, PH Principal Investigator
841 Moon Avenue
Los Angeles, CA 90065

Re: Vital Signs Core Metrics, IRB #I16-019, Request for Category 4

Exemption Dear Dr. Teutsch:

The Institutional Review Board has considered your request for a Category 4 Exemption set forth under 45 CFR 46.101 (b) for the above referenced protocol. Your request has been approved.

This approval is valid for one year, expiring on May 1, 2017. Prior to that date, we will send you a continuation/renewal form. Upon its receipt, please complete the form and return it to the IRB as soon as possible so that no IRB-related gap occurs in your approved project.

If you intend to modify this project in any way, please submit a revised protocol to the IRB for consideration and approval. In addition, you must promptly notify the Board if you encounter unanticipated problems involving risks to human subjects or other complications that may arise relative to the project's experimental procedures.
Please contact me at if you have any questions about this determination, or any other matter related to human subjects research at PHI.

Sincerely,

Debora Pinkas

Debora Pinkas, JD
IRB Administrator

## Appendix 2: Core Metrics One Page Overview

Project Background

The Public Health Institute (PHI) has deep roots in communities working to improve health through population-oriented approaches as well as improving access to and the quality of care. In this project, we will work with community members to identify a set of Institute of Medicine (IOM) Core Metrics at the local level that can be used for planning and evaluation.

In 2015, the IOM created the Vital Signs: Core Metrics for Health and Health Care Progress - (see brief report link here). The report takes a population health approach, though it also includes the quality and cost of clinical care.

Core Metrics - Four domain areas include:
Healthy people (population health), quality of healthcare, cost of healthcare, and engagement

Current efforts are underway to encourage its broad use and Health and Human Services (HHS) is likely to take a leadership role in doing so. One of the major challenges of the report, however, is that while general measures were recommended, they were not specified sufficiently to be used in a consistent fashion.

Brief Description of the Project

The project includes an initial convening to review the project, discuss potential measures (including identifying high priority topics not included in the Vital Signs set of metrics that are most relevant to your community), and most importantly, consider how the information can be presented in forms and formats that are most conducive to their use in collaboration, engagement, and planning. This will assist in providing greater specification for each of the IOM Core Metric areas (minimum of population health and engagement domains), and to determine how they can be implemented and used at the local level by community organizations, government agencies; in Community Health Needs Assessments (CHNAs); by healthcare providers, such as federally qualified health clinics (FQHC's); and many other stakeholders.

Your perspectives are essential to this endeavor and we invite you to participate and contribute your thinking. Dana Pearlman and Sue Grinnell will be contacting you to hear your perspectives through stakeholder interviews.

Once we get a local level of specificity for your community, we will develop an online "Vital Signs report card" for your community with interactive data visualizations through LiveStories based on locally defined measures for the population health and engagement domains. If data exists, we will also add quality of healthcare and cost of healthcare domains. We will examine the possibility of building a sustainable reporting tool that each community can use over time to assess progress. These reports will be presented to the communities (stakeholders convened earlier) at a second convening and a discussion facilitated. Reports will be suitable for sharing with other community partners and support your use of data and measurement for planning into the future.

Brief Report on Vital Signs Core Metrics link:
https://iom.nationalacademies.org/~/media/Files/Report%20Files/2015/Vital_Signs/VitalSigns_RB.pdf

Dana Pearlman and Sue Grinnell will be contacting a small number of stakeholders to interview them prior to the first convening in order to get a better sense of the community needs.

## Appendix 3: Key Informant Interview and Roundtable Discussion Guide (for PHI internal use)

Purpose
To begin the Core Metrics process,
Strengthen relationships with key stakeholders,
Gather pertinent information through exploration and questions
Ascertain the context that would support the engagement of the community and create useful outcomes for them when we complete the project

Outcomes
Why: clarify purpose of Core Metrics project
What: challenges and concerns that must be addressed to enable the success of this project (what might get in our way?)
Who: what key individuals need to be included in this process? Who else should we invite or talk with?
How: these interviews will inform the design of our in-person convening

Stakeholder interview Process
As we engage with stakeholders with our initial set of questions, we will reflect upon what we are learning about the communities and include additional questions to be explored as well as additional stakeholders that need to be included.
Identify which stakeholders to interview. Through initial conversations with the site point of contact, create a list of people in formal positions who are needed as well as non-formal people that have a stake in the outcomes (i.e., community members). Ideally, this is a microcosm of the entire system we are interested in including in impacting through our outcomes.
Dana and Sue will create questions to ask stakeholders and allow the interviews to flow naturally should the conversation turn into something different than anticipated. What we want to understand most is what is their context and how can this project most support their community to have the conversations they need to have and what measures would be most beneficial to them to create a more holistic and healthy community that is communicating and interconnected
Schedule calls, either in person, on the phone or through videoconferencing. Determine length of interviews (min of one hour).
Create an intention as an interviewer: May this interview support this community if reaching its potential as a healthy vibrant community where everyone's wellbeing is at the center of decision making.
May this process produce healthy communities? As an interviewer, listen deeply to what the participant is sharing with you, so much so that they sense this is a different experience than they have ever had, where someone genuinely cares and listens to their wisdom.

Set Context
As you are aware, there are a lot of measure-sets out there. IOM came together formed a small committee (Steven Teutsch- one of PHIs senior advisors) and looked at variety of measure sets. IOM project grew out of concern that there is not a standard set of measures that one can get at a local level that are important and meaningful. They are also often not useful to drive change. There were representatives of the clinical care community - as there has been a gap in this area of representative measures Their goal (criteria) was to identify a smaller set of measures, that could /would represent health in an area and drive action. The measure set is shown in the handout provided.

The Vital Signs metric set ended up with 4 domain areas, key element areas with 15 measures (best identified). The measures are available at a national level, but we are not sure yet if they are available at a local level. The purpose of this project is to test in a community how this measure set would work (to represent the health of a community and drive action). We recognize that there are other measures that could be added - topical areas - we can provide 3-6 total additional measures that may be more relevant locally based on needs and related to the domain areas. We have a staff research analyst Suzanne Ryan Ibarra who is gathering the Core Metrics data in your community in preparation for this work. Usability and feasibility - if we put together for the whole state - possibility as a standard measure set. This measure set is not meant to replace but to complement the current measures you may have in your community. Side note: Most recently some entities are using this framework - state of Vermont is using this and some health plans are starting to use this as well.

Your responses will be shared with our team, anonymously with other people's responses to get a better understanding of their community.

Set Context (for interviewer only):
Create a hospitable environment while conducting the interview.
We are interested in your personal wisdom about the system you are a part of. That is, if you had a magic wand, what would you do to...or from your experience, what are the biggest barriers in the community now. Let their perspective inform the conversation.
Observe yourself as the interviewer. Notice when you have judgments or barriers getting in the way to you fully listening. Listen from levels 3 (empathic listening) and 4 (generative listening) Seek to understand deeper structures of the system we are engaging, as though you are seeing it from above. Map out the system, see where connections, barriers, blocks and blind-spots exist. What mental models are you hearing? When something is spoken that you are curious about and you have rapport with the stakeholder, probe to find what is underneath what you are hearing and seek out patterns. What are their greatest concerns? When the conversation has come to place where it feels it is time to close, keep the door open. Is there a question you wish I had asked that I did not? Encourage them to contact you should they have any additions. Immediately following the interview, reflect and debrief the process with someone or on your own.

Questions
These questions are merely a launching board, the conversation may go in different directions based upon what is present, feel free to veer off into new territory all in service to getting at what context would support this community engaging in the Core Metrics.

Community Members

1. What is your role in health in Monterey?
2. When you hear the words healthy communities, what comes to mind?
3. As a community member of Monterey, how could this be in service to Monterey? [Show visual]


**TABLE 4-1** Core Measure Set

| Domain | Key Element | Core Measure Focus | Best Current Measure | Current National Performance |
|---|---|---|---|---|
| Healthy people | Length of life | Life expectancy | Life expectancy at birth | 79-year life expectancy at birth |
| | Quality of life | Wellbeing | Self-reported health | 66% report being healthy |
| | Healthy behaviors | Overweight and obesity | Body mass index | 69% of adults with body mass index (BMI) of 25 or greater |
| | | Addictive behavior | Addiction death rate | 200 addiction deaths per 100,000 people aged 15+ |
| | | Unintended pregnancy | Teen pregnancy rate | 26.6 births per 1,000 females aged 15 to 19 |
| | Healthy social circumstances | Healthy communities | High school graduation rate | 80% graduate in 4 years |
| Care quality | Prevention | Preventive services | Childhood immunization rate | 68% of children vaccinated by age 3 |
| | Access to care | Care access | Unmet care need reported | 5% report unmet medical needs |
| | Safe care | Patient safety | Hospital-acquired infection rate | 1,700 hospital-acquired infections per 100,000 hospital admissions |
| | Appropriate treatment | Evidence-based care | Preventable hospitalization rate | 10,000 avoidable per 100,000 hospital admissions |
| | Person-centered care | Care match with patient goals | Patient-clinician communication satisfaction | 92% satisfied with provider communication |
| Care cost | Affordability | Personal spending burden | High spending relative to income | 46% spent >10% of income on health care or were uninsured in 2012 |
| | Sustainability | Population spending burden | Per capita expenditures on health care | $9,000 health care expenditure per capita |
| Engaged people | Individual engagement | Individual engagement | Health literacy rate | 12% with proficient health literacy |
| | Community engagement | Community engagement | Social support | 21% with inadequate social support |

4. From your vantage point: What is missing?
5. Do you think this could be helpful?

Stakeholders

1. What does health mean to you?
2. When you hear “healthy community” what do you think of or imagine?
3. What is your vision for a healthy community for …..
4. What is meaningful to you in your community? And how would you know when it is in place (how would you measure)?
5. What top three challenges do you/does your community face?
6. Is there a metaphor that describes how health in the community currently works? Is there a metaphor that describes how you wish it would work? Why that metaphor?
7. Do you know if the community has done a visioning process? What were the outcomes? Do you see evidence of the process? What support is needed to make the vision happen?
8. In your community/network what strengths do you see that create health for the community
9. In your community, what do you see as barriers or obstacles for people to be healthy?
10. What issues they sense in their communities are related to health. What are the problems? Challenges may be thinking narrowing as opposed to larger environmental and social issues. We are interested in those broader issues, then find out what is most important to them.
11. What do you see in your community that is most concerning?
12. What specific health related issues do you see as the greatest challenge?
13. If you were to map out the system, where would you see flows? Where would you see blockages?
14. Share a visual of the Core Metrics and ask how can it be an add on or enhance what they are already doing


**TABLE 4-1** Core Measure Set

| Domain | Key Element | Core Measure Focus | Best Current Measure | Current National Performance |
|---|---|---|---|---|
| Healthy people | Length of life | Life expectancy | Life expectancy at birth | 79-year life expectancy at birth |
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| | Healthy social circumstances | Healthy communities | High school graduation rate | 80% graduate in 4 years |
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| Engaged people | Individual engagement | Individual engagement | Health literacy rate | 12% with proficient health literacy |
| | Community engagement | Community engagement | Social support | 21% with inadequate social support |

15. If you could focus on any of these Core Metrics, which ones would be most beneficial? What would you measure, specifically
16. What are you currently measuring
17. Could these be comparable or go together (core measures and current data)?
18. How can these measures support you and your community?
19. What kind of data are you using? If they could have access to any data, what would it be?
20. NOTE: space for convening. Do they have a space they normally meet, is it ok for them to meet there? Any barriers? Neutral space? Accessible?

## Appendix 4: Stakeholder Survey

**Population Health Innovation Lab: Core Metrics Community Stakeholder Survey**

**Background**

In a recent report, Vital Signs: Core Metrics for Health and Health Care Progress , the Institute of Medicine (IOM) Committee on Core Metrics for Better Health at Lower Cost proposed a set of core measures intended to promote understanding and improvement of health outcomes at the national, state, and local levels.

The report suggests that health improvement measurement should focus not only on the healthcare system, but also on socioeconomic determinants of health (e.g. housing, education, and environment).

The Core Metrics include measures from four domain areas:

1. Healthy People
2. Care Quality
3. Care Cost
4. Engaged People

| Core Metrics Primary Measures | |
|---|---|
| **Domain** | **Core Metric Measure** |
| Healthy People | Life expectancy at birth |
| | Self-reported health |
| | Body mass index |
| | Addiction death rate |
| | Teen pregnancy rate |
| | High school graduation rate |
| Care Quality | Childhood immunization rate |
| | Unmet care need |
| | Hospital-acquired infection rate |
| | Prevention hospitalization rate |
| | Patient-clinician communication satisfaction |
| Care Cost | High spending relative to income |
| | Per capita expenditures on healthcare |
| Engaged People | Health literacy rate |
| | Social support |

## Core Metrics Secondary Measures

| Core Measure Focus | Secondary Measures |
|---|---|
| **Life expectancy** | 1. Infant Mortality<br>2. Maternal Mortality<br>3. Violence and Injury Mortality |
| **Well-being** | 4. Multiple chronic conditions<br>5. Depression |
| **Overweight and obesity** | 6. Activity levels<br>7. Healthy eating patterns |
| **Addictive behavior** | 8. Tobacco use<br>9. Drug dependence/illicit use<br>10. Alcohol dependence/misuse |
| **Unintended pregnancy** | 11. Contraceptive use |
| **Healthy communities** | 12. Childhood poverty rate<br>13. Childhood asthma<br>14. Air quality index<br>15. Drinking water quality index |
| **Preventive services** | 16. Influenza immunization<br>17. Colorectal cancer screening<br>18. Breast cancer screening |
| **Care access** | 19. Usual source of care<br>20. Delay of needed care |

| Core Measure Focus | Secondary Measures |
|---|---|
| **Patient safety** | 21. Wrong-site surgery<br>22. Pressure ulcers<br>23. Medication reconciliation |
| **Evidence-based care** | 24. Hypertension control<br>25. Diabetes control composite<br>26. Heart attack therapy protocol<br>27. Stroke therapy protocol<br>28. Unnecessary care composite |
| **Care match with patient goals** | 29. Patient experience<br>30. Shared decision making<br>31. End-of-life/advanced care planning |
| **Personal spending burden** | 32. Health care-related bankruptcies |
| **Population spending burden** | 33. Total cost of care<br>34. Health care spending growth |
| **Individual engagement** | 35. Involvement in health initiatives |
| **Community engagement** | 36. Availability of healthy food<br>37. Walkability<br>38. Community health benefit agenda |

1. **Out of the above Core Metrics secondary measures, which are top priorities for your community?** Please use the drop-down lists below to select 5 secondary measures in order of priority.

   Priority #1: _____

   Priority #2: _____

   Priority #3: _____

   Priority #4: _____

   Priority #5: _____

2. **What would be the most useful way to report the measures selected above for your community?**

   Select all that apply.

   - By age
   - By gender
   - By race/ethnicity
   - By geography (i.e., zip code, census tract, or city)
   - Don't know

**Additional Health-Related Needs**

3. **In addition to the Core Metrics Measures listed previously, what do you think are the three most important needs that affect health in your community?** Please describe each using the text boxes below, starting with the most important need:

   Health Need #1: _____

   Explain Why: _____

   Health Need #2: _____

   Explain Why: _____

   Health Need #3: _____

   Explain Why: _____

4. **What data or measures are needed to better understand the health needs you listed above?**

   Data for Health Need #1: _____

   Data for Health Need #2: _____

   Data for Health Need #3: _____

5. **What geographic level would be most useful for reporting the measures you selected?**

   - o Zip code
   - o City
   - o Census tract
   - o Don't know
   - o Other (please specify)

**Shared Measure Sets**

A shared measure set is a collection of common variables used by collaborating groups or entities to measure health and health-related issues.

6. **How would your community use a shared measure set for improving community health?** Please describe:
   _____

7. **What does shared data in action mean to you?** Please describe:
   _____

8. **Is shared data in action important to you?**

   - o Yes
   - o No
   - o Don't know

9. **How can data be actionable and useful for your county's work?** Please describe:

_____

10. **Is there anything else you think we should know?**

_____

## Appendix 5: Convening #1 Summary, Fresno, CA

Fresno Core Metrics Convening Summary
August 23th 9:30-4:30 pm

Core Metrics: Driving Change towards Health and Well-Being

On August 23rd, a group of approximately 22 members of the Fresno Community working to create well-being among the Latino population gathered to learn about the Vital Signs Core Metrics and inform what to pay attention to when thinking about using data to drive action.

Objectives of the Day included:

- Understand Core Metrics: what they are and how they can help us make our community healthier
- Collectively explore how the preliminary set of Core Metrics can be used to set a course of action
- Identify any critical gaps the community sees in the measures themselves
- Familiarize them with LiveStories and how that tool may serve them in driving action

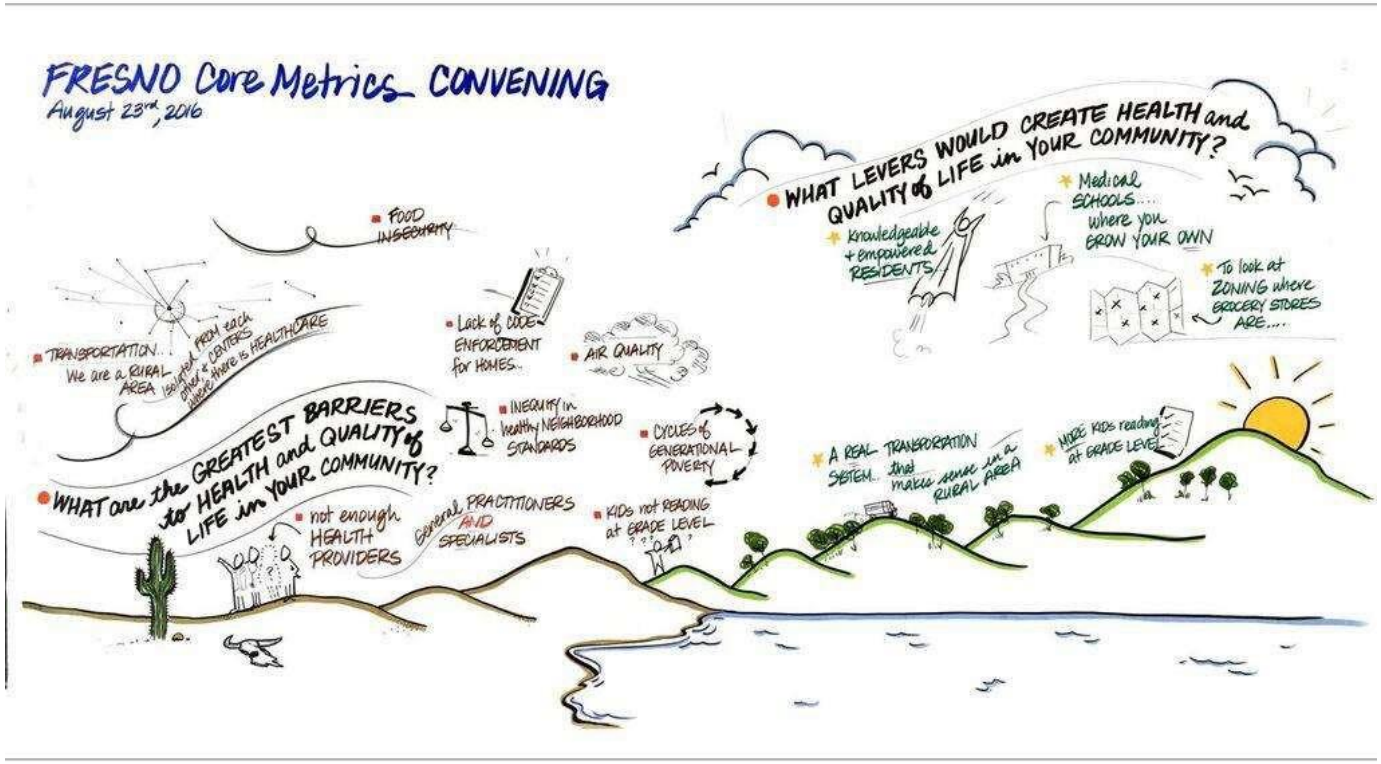
Short Agenda

| | |
|---|---|
| 9:00 | Breakfast and registration |
| 9:30 | Co-creating a visual map of barriers and levers to health and well-being |
| 9:45-10: 30 | Welcome, Framing and Flow of Agenda and Whole Group Check-In Circle |
| 10:30-10:45 | Break |
| 10:45-12:00 | Presentation + Dialogue: What is Core Metrics + LiveStories? How can it help us drive change? |
| 12:15-1:15 | On-site lunch |
| 1:15-3:00 | World Cafe: Co-exploring Core Metrics + Live Stories + Our Story in Fresno and the Latino Population |
| 3:00-3:20 | Break |
| 3:20-4:30 | Next steps |
| 4:30 | Closing |

The morning began with breakfast and an invitation to populate a visual map created by an artist and graphic recorder, asking participants to answer the following questions:

1. What levers (i.e. transportation, access to healthy food, mental health services--visually in a bubble on the graphic) would create health and quality of life in your community?

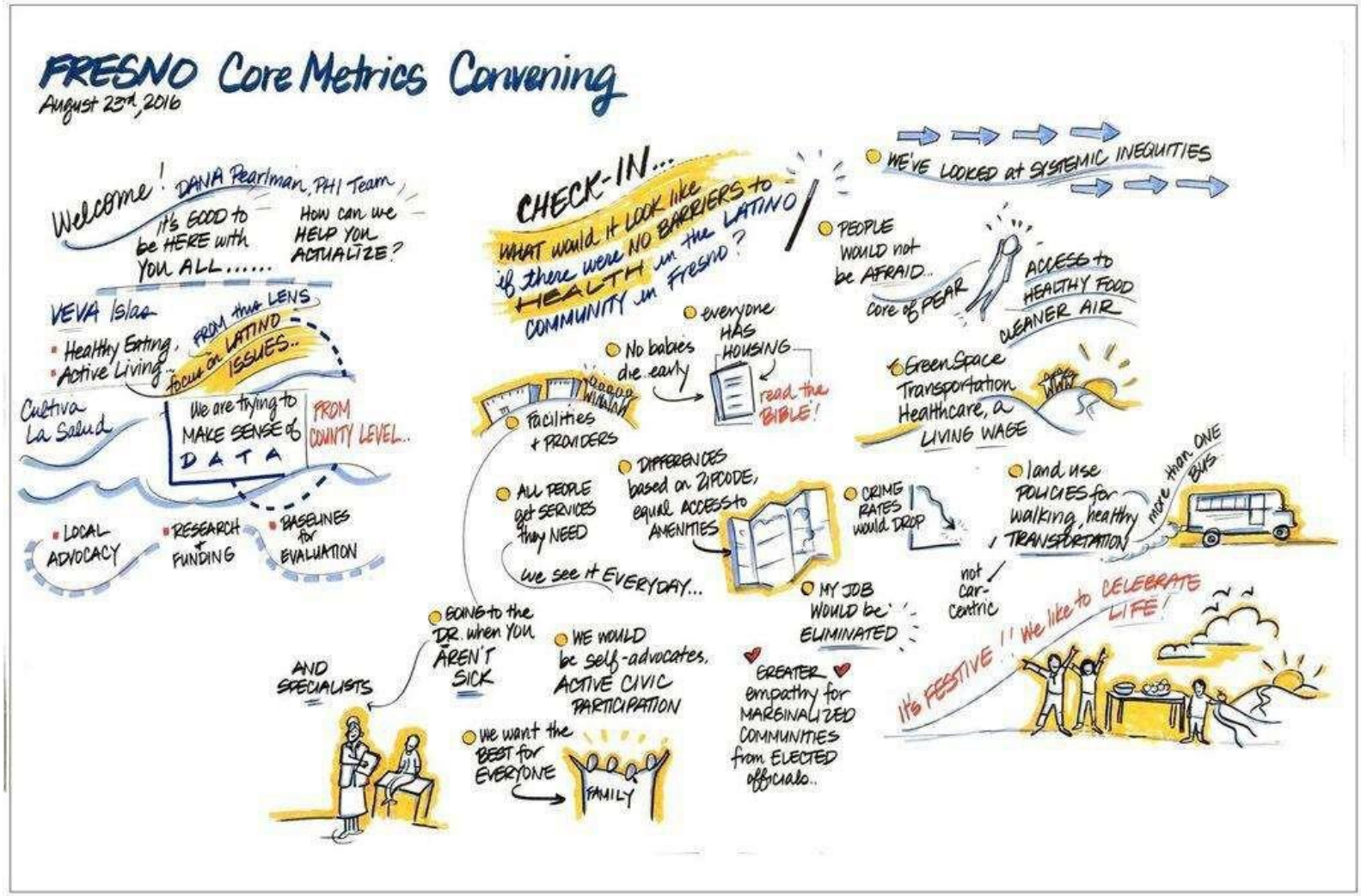
2. What are the greatest barriers to health and quality of life in your community today?



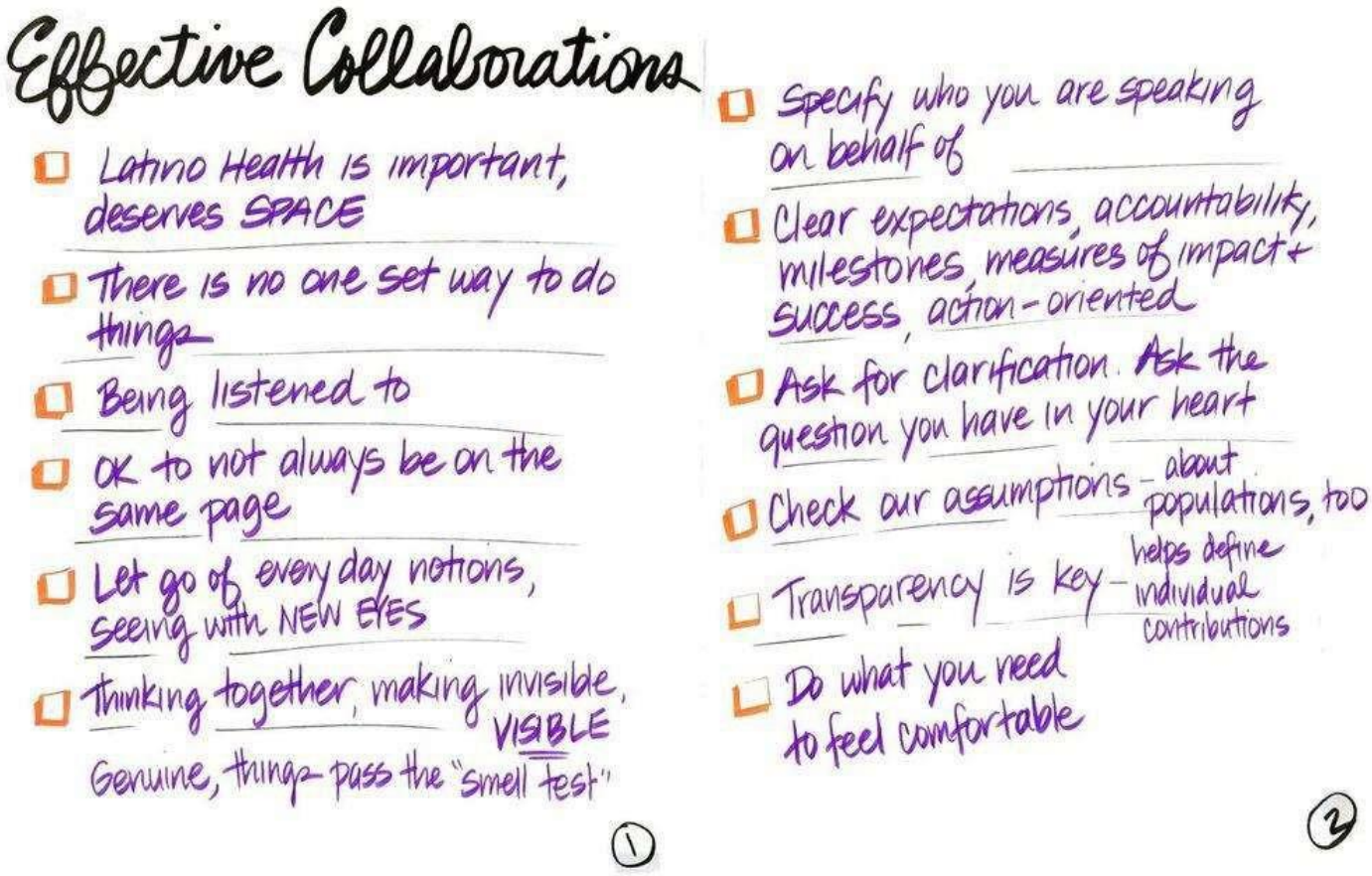
We then began with the whole community in a circle and welcomed the participants, shared the objectives and agenda for the day. We set the context, explaining:

Today is about co-exploring health and well-being in Fresno with the Latino Coalition + the community you serve. What we put our attention on through metrics can drive change towards greater well-being. We want to expose you to Core Metrics as a potential tool to help them collectively think together about how to drive change towards health, quality of life and equity through access to data.

Genoveva Islas, our local partner and curator of the invitation list, explained to the participants why she invited them to the convening. She also explained her intent for the work and her hopes for the day.


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 that 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
No babies die early
read the BIBLE!
Green Space
Transportation
Healthcare, a LIVING WAGE
facilities + PROVIDERS
DIFFERENCES based on ZIPCODE, equal ACCESS to AMENITIES
ALL PEOPLE get SERVICES they NEED
we see it EVERYDAY...
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
GREATER empathy for MARGINALIZED COMMUNITIES from ELECTED officials..
We want the BEST for EVERYONE
FAMILY
It's FESTIVE!! We like to CELEBRATE LIFE!

We then co-created our operating principles for effective collaboration and asked what would enable their full participation this day.




We then did a check-in circle, where participants are asked to speak from both their minds and hearts. We asked to offer their names, where they are working and what would it look like if there were no barriers to health in Fresno community? (see graphic

above)

Steven Teutsch, Principal Investigator for the Vital Signs Core Metric project then gave an overview, explaining:

- Core Metrics,
- the purpose of the project, and
- the intent to drive change

We then asked participants to get into triads and answer, based upon what you are learning, what strikes you? We then heard from the groups to see what patterns were emerging or divergent thinking.


CORE METRICS
Steven Teutsch
INSTITUTE of MEDICINE
COMMITTEE
met for a FEW YEARS
good to use data SETS
at COMMUNITY LEVEL
traditionally-minded
NAT'L
SMALLER SET
HEALTHY PEOPLE
Major determinants of HEALTH.
INTENDED to be USED in different CONTEXTS
QUALITY of CARE
ENGAGED PEOPLE
CARE COST
Can you get these at a LOCAL LEVEL?
If so, can they DRIVE ACTION + CHANGE?
AND SCALE?
WHAT STRIKES YOU ABOUT the CORE METRICS SET?
Pair Conversations Pt. 1
WAYS to COLLECT MENTAL HEALTH DATA
GAP
RESIDENTS have immense DAILY STRUGGLES
Helicopters in neighborhoods
stray DOGS
DATA can HELP us see BLIND SPOTS
AIR QUALITY, WATER QUALITY
LINKS to POVERTY
NEED for HEALTH DISPARITIES
NAT'L PERFORMANCE DATA DOESN'T reflect THIS VALLEY
LIVESTORIES
Suzanne Ryan-Ibarra
Data Platform
STORYTELLING APPROACH
HEALTH DATA+
DEMO
FRESNO CORE METRIC SET
Pair Conversations Pt. 2
POSITIVE TRENDS
Try to FIND the SILVER LINING of the DATA
ability to survive
entrepreneurship
IMPORTANT for us to select DATA....
that BRING DOWN
RACIAL + ETHNIC VARIABLES
also need to UPLIFT where we DON'T HAVE DATA
NEED to INCORPORATE real DATA + STORIES to lift up what is HAPPENING
HOW can we BOOST DATA SETS?
PHILANTHROPY, FOUNDATIONS
"THIS is HOW YOUR NEIGHBORHOOD CAME to be"....
DATA BROKEN down by NATIVITY + NAT'L origin
TYING DATA to CAL ENVIRO SCREEN v 2
UNDOCUMENTED COMMUNITY
VOTER REGISTRATION, (vs.) SCHOOL INVOLVEMENT
BETTER MEASURE
What is the STORY WE WANT to TELL?

Next, Suzanne Ryan Ibarra, Senior Research Scientist and epidemiologist presented LiveStories, a data software platform that makes data accessible to anyone through a visual and user friendly website which tells the story behind data. Suzanne gave a presentation that articulated how Fresno may use this to drive action in their communities.

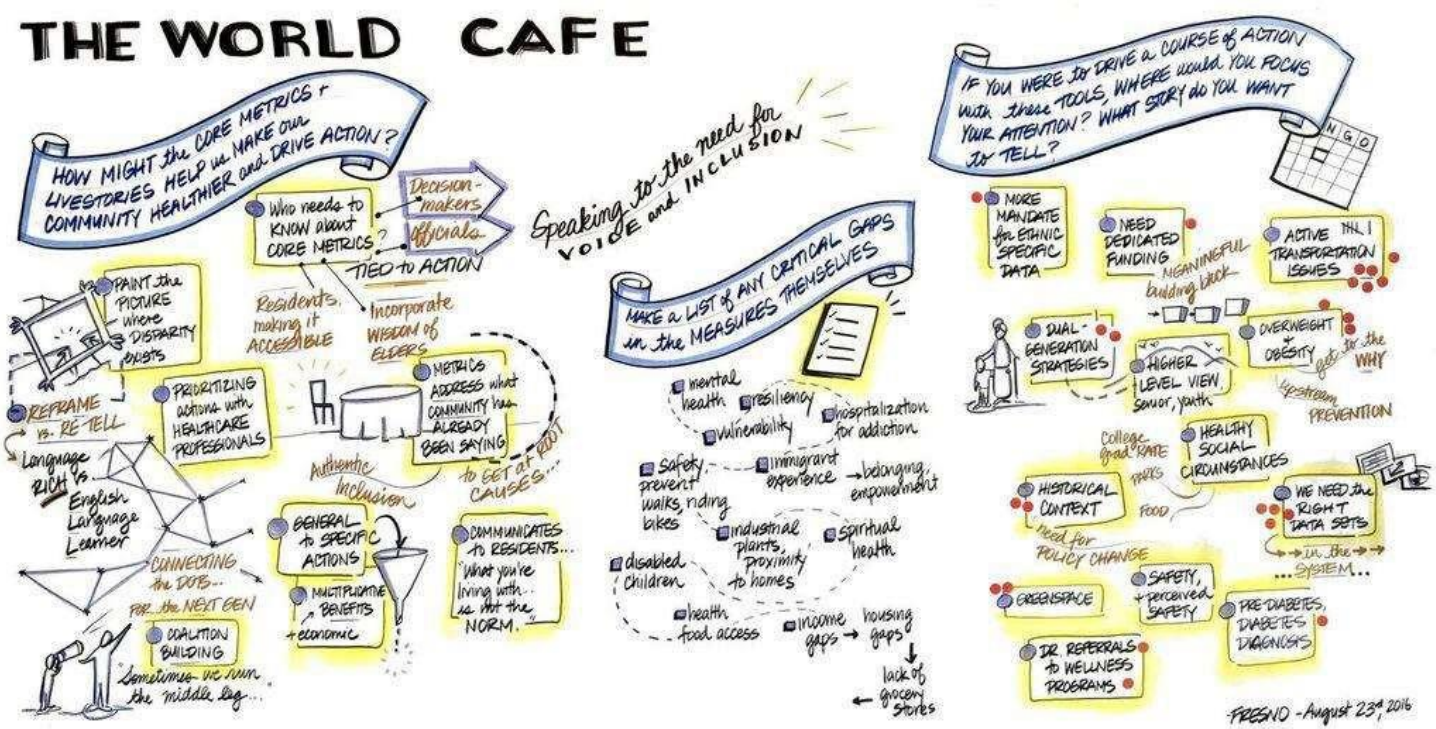
Again, we had the participants get into groups of three to explore and reflect on LiveStories. We asked them to answer the questions: What struck you? What would you like to see in a LiveStories format? What story do you want to tell? (see above graphic)

We then used a methodology called World Cafe, where small groups of four explore questions presented to them, and then they switch to a new group of four. It is a methodology that helps to surface themes, patterns and new ideas. It also helps to surface collective wisdom in support of moving towards collective action.

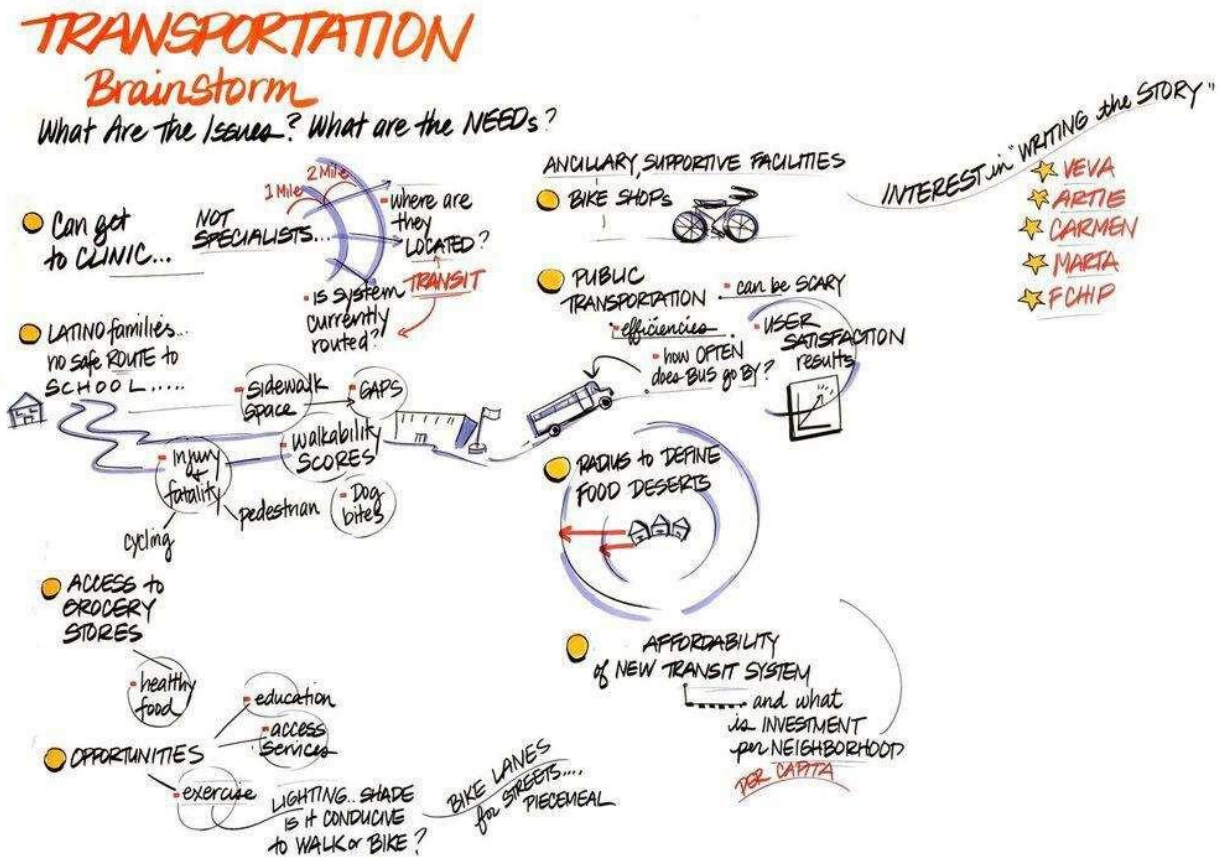
We asked the following questions:

Round 1 How might the Core Metrics + LiveStories help us make our community healthier?
Round 2 Are there any critical gaps in the measures themselves? We collected a list of gaps
Round 3 We want to get to a single issue we are going to be working on. If you were to drive a course of action with these tools, where would you focus your attention? What story do you want to tell?

We then prioritized their topics of interest and it was determined to focus attention on active transportation to create more health and well-being among the Latino population in Fresno.


THE WORLD CAFE
HOW MIGHT the CORE METRICS + LIVESTORIES HELP us MAKE our COMMUNITY HEALTHIER and DRIVE ACTION?
Who needs to KNOW about CORE METRICS?
Decision-makers
officials...
TIED to ACTION
Residents making it ACCESSIBLE
Incorporate WISDOM of ELDERS
Speaking to the need for VOICE and INCLUSION
PAINT the PICTURE where DISPARITY exists
REFRAME vs. RE-TELL
Language RICH vs. English Language Learner
PRIORITIZING actions with HEALTHCARE PROFESSIONALS
METRICS ADDRESS what COMMUNITY has ALREADY BEEN SAYING
Authentic Inclusion
to GET at ROOT CAUSES...
GENERAL to SPECIFIC ACTIONS
MULTIPLICATIVE BENEFITS +economic
COMMUNICATES to RESIDENTS... "What you're living with... is not the NORM."
CONNECTING the DOTS...
FOR... the NEXT GEN
COALITION BUILDING
Sometimes we run the middle leg...
MAKE a LIST of ANY CRITICAL GAPS in the MEASURES THEMSELVES
mental health
resiliency
vulnerability
hospitalization for addiction
safety, prevent walks, riding bikes
immigrant experience
belonging, empowerment
industrial plants, proximity to homes
spiritual health
disabled children
health food access
income gaps
housing gaps
lack of grocery stores
IF YOU WERE to DRIVE a COURSE of ACTION with these TOOLS, WHERE would YOU FOCUS YOUR ATTENTION? WHAT STORY do YOU WANT to TELL?
N.G.O.
MORE MANDATE for ETHNIC SPECIFIC DATA
NEED DEDICATED FUNDING
MEANINGFUL building block
ACTIVE TRANSPORTATION ISSUES
THL
DUAL-GENERATION STRATEGIES
HIGHER LEVEL VIEW, Senior, youth
OVERWEIGHT + OBESITY
get to the WHY
upstream PREVENTION
College grad RATE
HEALTHY SOCIAL CIRCUMSTANCES
HISTORICAL CONTEXT
PARKS
FOOD
need for POLICY CHANGE
WE NEED the RIGHT DATA SETS
in the SYSTEM...
GREENSPACE
SAFETY, + perceived SAFETY
PRE-DIABETES, DIABETES DIAGNOSIS
DR. REFERRALS to WELLNESS PROGRAMS
FRESNO - August 23rd, 2016

We then brainstormed collectively what the main issues and needs in transportation could be explored.



We invited interested parties to help write up the LiveStories platform and people volunteered to continue the work.

We explained that we would come back later, in December to share custom websites for Fresno County built using the LiveStories platform and explore how it could be used to create well-being in Fresno.

We closed the day asking each participant about what they are grateful for and then we closed the day.

## Appendix 6: Convening #1 Summary, Monterey, CA

August 22, 2016
10am-1pm

Core Metrics: Driving Change towards Health and Well-Being

On August 22nd from 10am-1:00 pm, we had a convening with a select group of stakeholders in Monterey County. The stakeholders represented diverse organizations throughout the county with unique missions, but united around a common theme of creating an environment to foster health. Our objectives were to support participants in:

- Understanding the Core Metrics: what they are and how they can help make Monterey County healthier
- Exploring how the Core Metrics can be collectively used as part of Monterey's Community Health Assessment; related data and health improvement strategies
- Identifying any critical gaps the community sees in the measures themselves
- Familiarizing them with LiveStories and how that tool may serve them in driving action
- Learning what other participants are working on to make Monterey County healthier and what data activities each other is engaged in

**High-level agenda**

- 9:30 Registration
- 10:00 Welcome, Objectives and Framing the Convening
- 10:20 Check-circle
- 10:45 Presentations on Core Metrics + LiveStories + Impact Monterey County
- 11:15 World Cafe - small group dialogue
- 12:45 Closing
- 1:00 End

We began the conversation by welcoming participants, setting the context of why we are convening and how the meeting will take place by presenting the agenda. We reviewed our hopes for the convening and objectives.

Krista Hanni shared her hopes for the day and explained why these particular stakeholders were invited, which was due to their involvement in creating health for the community of Monterey County.

Steven Teutsch explained to the participants why Monterey County was selected for this project, the reasons included that they:

- Are engaged community leaders
- Desire having a set of indicators
- Are willing to demonstrate the potential value of the Vital Signs metrics

We then co-created our Operating Principles, or agreements about how we will engage and interact with one another throughout the process. This was an opportunity to invite full participation by tending to what each of the attendees needed to share their perspectives. Ideas named included: understanding the purpose of the convening, transparency and trust.

Next, we did a full group check-in circle, where we asked each participant to share their name,

organization and answer the question: What is the biggest leverage point you see that could bring well-being to Monterey County through collective action? The purpose of this opening circle was to build community, learn about who is in the room and listen to the many different perspectives present.

Steven Teutsch then gave a presentation on the Core Metrics, the purpose of the project and intent to use a frugal set of measures amongst diverse stakeholders to drive action.

Suzanne Ryan-Ibarra then shared a visual PowerPoint slide of LiveStories. Examples of websites built using this tool were offered to demonstrate how it utilizes data to create a beautiful visual story to evoke action.

Suzanne talked about the potential of LiveStories to focus on particular areas to help drive change, as well as, weave a story people connect to.

Krista Hanni then shared the four priority areas from Impact Monterey County, including Safety, Physical Health and Mental Health, Educational Attainment, and Economic Self-Sufficiency.

Next, we utilized a methodology called World Cafe, which is used to surface collective wisdom through both small group dialogue and whole group sharing. During this process, a round of three different questions is discussed to surface diverse perspectives. After each question, people switch tables, go talk to new people and have the opportunity to cross-pollinate ideas. After each question round, we would listen to what surfaced at each of the tables to hear any patterns or themes emerging.

Question Round 1: How might the Core Metrics be helpful to you and what you are already doing with the 4 priority areas?

Harvest: What are you working on related to Impact Monterey's 4 Priority Areas?

Question Round 2: What, if any, critical gaps do you see in the measure set themselves related to the 4 priority areas for Impact Monterey? What's missing?

Harvest: What are the gaps?

Additional Gaps

Key Themes
Gap 1

Key Themes
Gap 2

Question Round 3: Given all that you have heard today - how might we move forward to spur collective action with this shared knowledge base? What could we do together?

Harvest: What are the priority areas we can focus in on for the LiveStories report?

In conclusion, the group decided on the following Action Items: 1) Add measures of perceived and objective safety to the Core Metrics set and incorporate into the Core Metrics LiveStories report, 2) Create a LiveStories report that focuses on safety, and 3) Translate all LiveStories

reports for this project into Spanish.

We asked who might be interested in helping to craft the LiveStories report, and we had 5 volunteers, or interested parties that would help continue the work. We will partner with these volunteers to review and revise the LiveStories reports, and return in December to present LiveStories and explore how it may be used to create greater well-being in their community and drive action.

## Appendix 7: Convening #2 Summary, Fresno, CA

Fresno Core Metrics

Dec 7th
Radisson Fresno Conference Center: Skyview Room

Purpose + Objectives of convenings

- Leave the Fresno Group w. Core Measure Set + Platform (LiveStories) for their continued use into the future as an advocacy tool.
- Share the LiveStories Platform and explore where do we go from here? How can platform and data be helpful?
- Explore how this process has been useful.
- Explore next steps around Transportation and Safety in Fresno

High Level Agenda
12:00 Lunch
1:00 Framing, objectives and agenda
1:30 Check in - in pairs
1:45 LiveStories Presentation + Dialogue
2:15 World Cafe
Closing
4:30 Gratitude and Commitments

After lunch with the participants, we gathered in a circle and shared the objectives and framing for why we were convening.

Genoveva Islas, the community leader we worked with gave greater context, naming that the convening was about “democratizing the data” and giving our community and Cultiva La Salud greater access to data to drive needed change.

Next, we did a check in process - in pairs, asking them to each answer: what brought you here today? What do you hope to get out of the day?

Suzanne Ryan Ibarra shared the LiveStories website on the Core Metrics for Fresno County, then more specifically on their 5th domain: Active Transportation, which was identified by as a priority area during the first Convening in August. Suzanne Ryan-Ibarra offered some ideas about how the tools may be used going forward:

- Policy advocacy to drive change
- Track indicators over time to report to stakeholders (government officials, advocates, community members)
- Make data accessible for community-based groups so they can use to drive policy change or apply for grants
- Incorporate data, photos, or text from LiveStories into other information platforms

Then we moved into a World Cafe process to harness the collective wisdom of the group and asked question in small groups of 4, rotating to new groups after each question and hearing report outs after each round. The questions explored included:

1. How might we use these tools (Core Metrics and LiveStories) for advocacy /driving change?

Results:

Supports further advocacy for identified issues /education/targeted efforts
Concerted applications for funding to support infrastructure
Latino centric data – Important to have this information to drive resources where most needed and where investments can be made (equity vs deficit)
Invite the community in to draft the messaging (education for them/ advocacy
We all gain from this data/resource allocation
Use the tool with residents /elected officials and need to make sure it is in plain language and actionable
Platform can be nimble/modified/adaptable
The data can demonstrate the inequities on how funding decisions are made
Messaging this issue will be important
Needs to be trustworthy
Simplified language
Use of analogies are helpful to have in messaging
ADA example

2. How might we work together with this tool to move actions forward? How can we maintain it in the future?

Results:

Identify a group to carry the work forward
Way to move the action forward to increase representation of Latino populations
Need to get the Caltrans count data
Currently it is only available for north Fresno. Need it for south Fresno
These data are used for grant opportunities connected to infrastructure
Need resources for walking and biking data
Social vulnerability / poverty: with no data there are no resources
Currently there is no way to get these data
Suggest a volunteer team to track data (this can be recognized as data by Caltrans)
Asset map of members who are working on this issue
Start with this group
Develop a work plan
Possibly expand to a regional focus
Connect to other counties in the region with a focus on Latinos in Central Valley communities
Look at methods to cross share data
Regional local health jurisdictions being brought together
Central Valley health policy
Partnership for San Joaquin valley
CA4Health

Possibly go to these groups and present the LiveStories

3. Commitments/ Next Steps (not all had names or are actual commitments)

Results:

Vision: Fresno is the most active transit community in California (US)
Continue in REACH project on Active Transportation

Neighborhood investments Esther
How can we get these data?

- Track the data and link to work and outcomes
- Increase resources to support infrastructure
- Gather data to inform resource allocation at the city and county level
- Continue to work on capacity building and leadership
- Bike kitchens – currently no way to repair bikes.
- Focus on training youth and adults how to repair bikes
- Microenterprise – creating the demand for services and businesses
- Need more advocacy for animal control = impacts use of transportation
- Where there are dogs - impacts walking, biking and use of public transit
- Match the data with needed investments
- Track to see impact on issues
- Share the LiveStories site with city council
- Bring together neighborhood investors – asset map and identify ways to work better together / human development and service leadership

Offer of a proven strategy for bike and walking county – Suzanne Ryan Ibarra
Update the LiveStories site /transition and train staff Suzanne Ryan Ibarra
Write up the information from the day and commit to finding other resources Sue Grinnell
Environmental justice task force and social equity – SE Fresno
Working to build a partnership with the city - hold them accountable
Increase communication with city and share the vision
Use the Portland Neighborhood Association as a best practice
Create a liaison between the neighborhood association and the city
Transportation equity

Last, we had the participants do an assessment on the Core Metrics work and what they think the utility of this would be for other locations. What was useful, what not, was it a good use of their time, what could we have done better? Any advice for replication?
Then we closed by sharing our gratitude for our time together

## Appendix 8: Convening #2 Summary, Monterey, CA

Monterey Convening Write Up
When: December 8, 10:00-1:00 pm (Lunch from noon to 1pm)
Location: Harden Foundation bunkhouse

Purpose + Objectives of convenings 1 or 2 things that you want to leave with

- Leave Impact Monterey County. Network with Core Measure Set + Platform (LiveStories) for their continued use into the future.
- Share the LiveStories Platform, Core Measure Set with Impact Monterey branding and explore where do we go from here?
- See how Core Metric indicators may be useful to Impact Monterey
- Identify potential Champions to steward initiatives or collaboratives
- Identify how has this process been useful and what could be improved for future replication

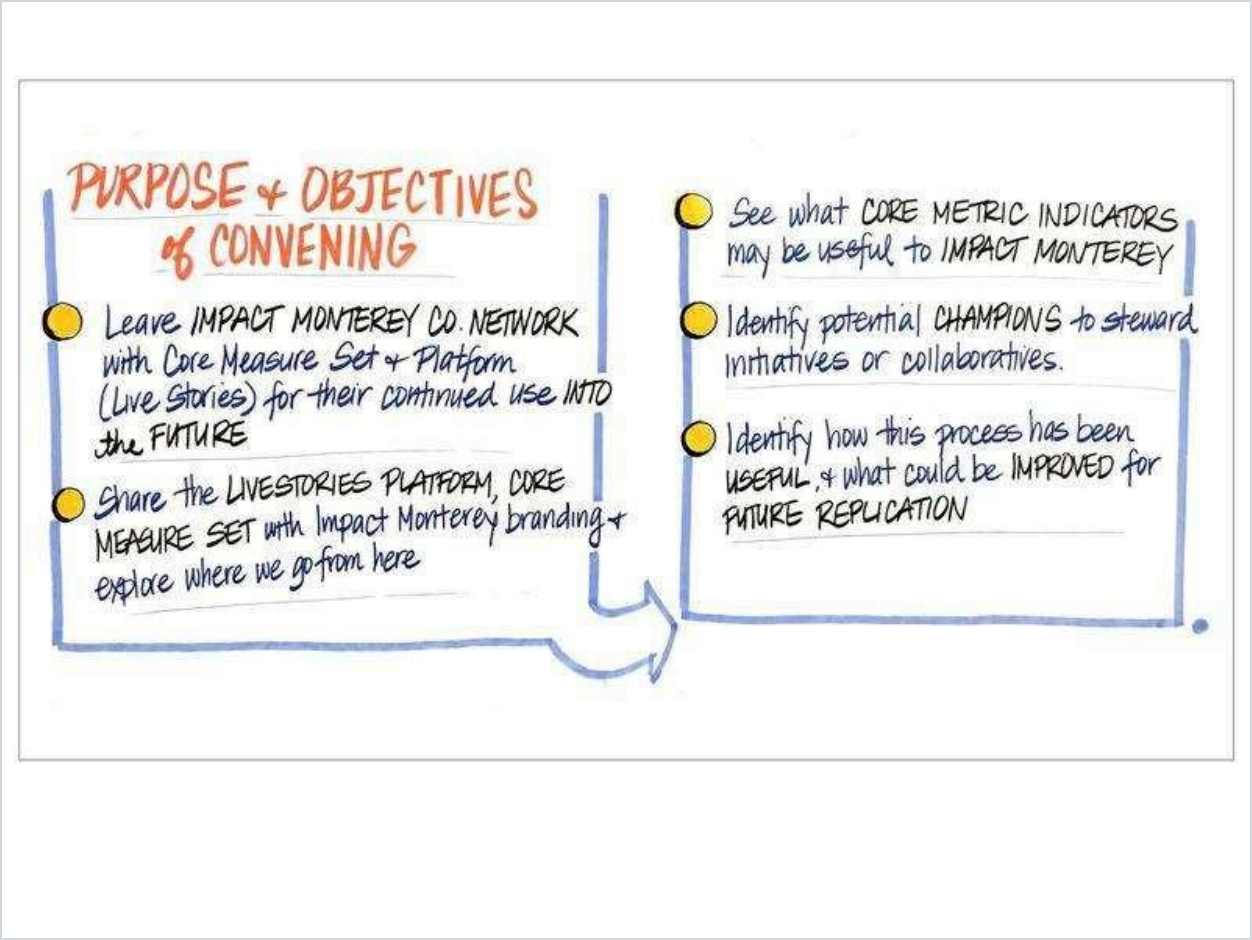
High Level Agenda

- Welcome and Framing of today's Purpose
- Check-in
- Core Metrics, LiveStories and Impact Monterey - How do they work together?
- Live Stories Presentation
    - Safety: How might you use these tools to drive action?
- Core Measures
    - What indicators do you think are important to Impact Monterey?
- Identifying potential Champions
    - List any potential champions for initiatives listed
- How has these engagements be supportive? What could be improved upon?
- Closing, next steps, commitments

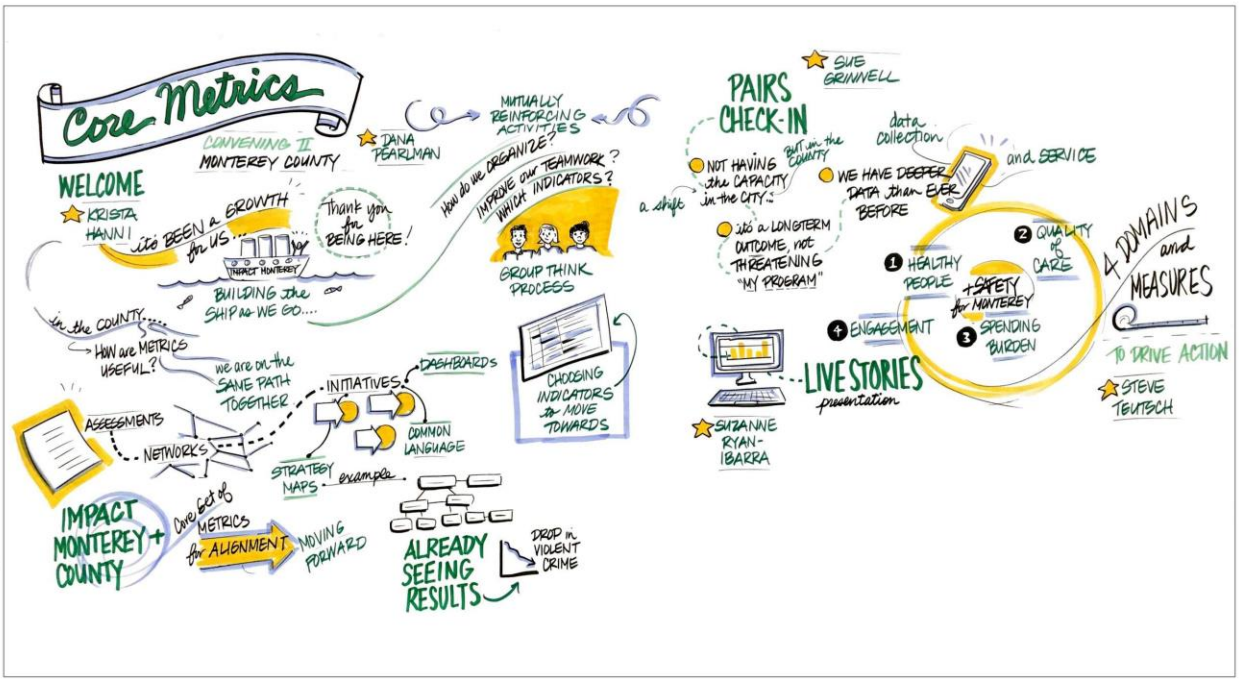
Professional made Graphic Design Boards

- Champion Board + list of Initiatives/collaboratives identified by Krista that need champions (may not be in the room) and we need potential champions contact information; who do participants know that could champion these?
- Core Metrics Board - for participants to prioritize indicators
- Safety - we will be asking them "how might these tools be used to drive action in Safety in Monterey County?"

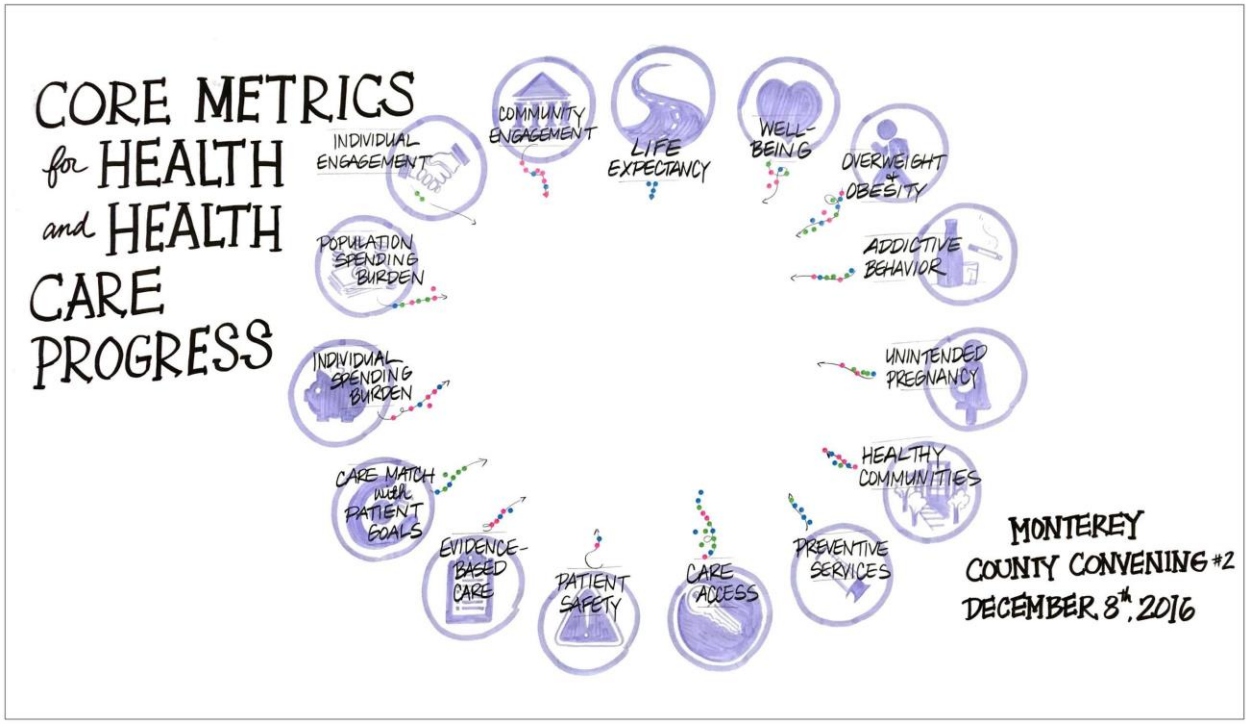
We began the 2nd convening at 10:00 am, with 17 stakeholders from Monterey County. We welcomed everyone and reviewed the purpose for the day and had everyone share their name and organization with the rest of the room to show who was present.



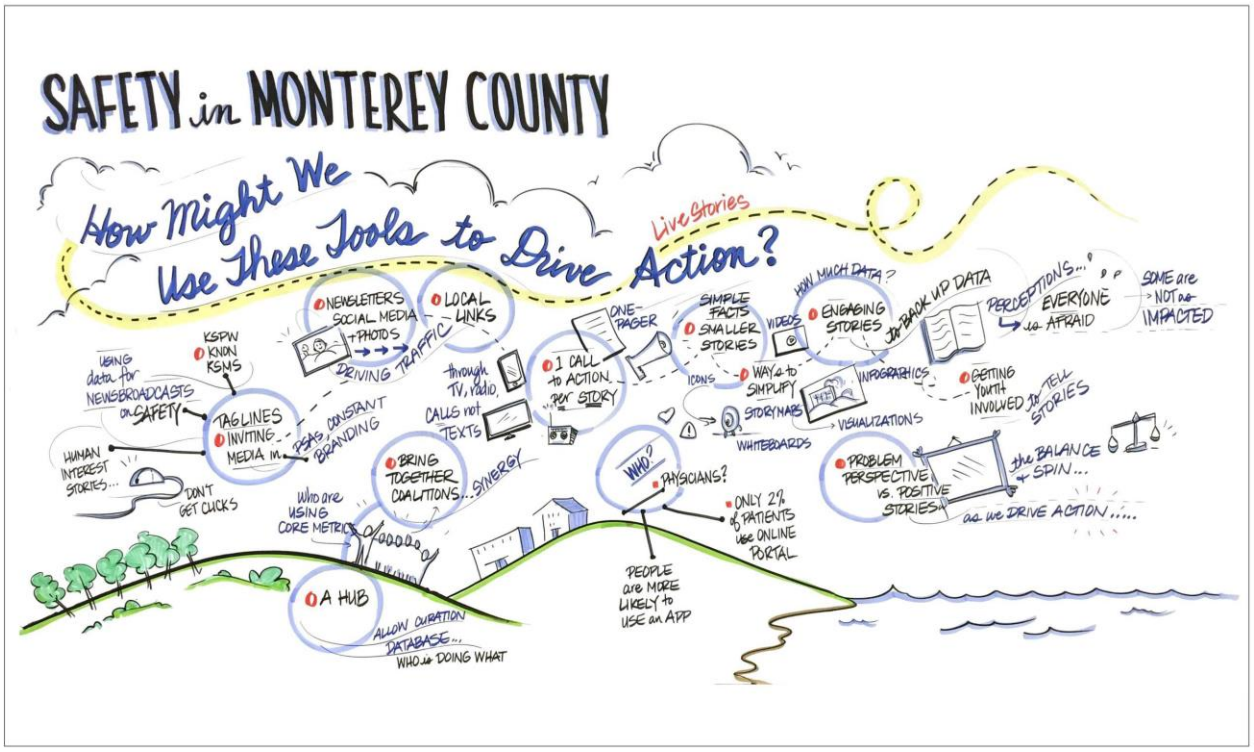

Krista Hanni, from the Monterey County Health Department set the context about how the Core Metrics work and LiveStories fits-in with the work they are doing for Monterey Impact. The convening would serve as a round of feedback for integrating the Core Metrics indicators into Impact Monterey, after a gap in health indicators was discovered at the Impact Monterey meeting on Nov. 28th. Krista explained that our work was part of an iterative process, and she was seeking feedback on what indicators may be useful in Monterey County.
We then went into a check in process in pairs, asking participants to share- What are you observing around indicators in Monterey County?




After the check in process, there was a LiveStories presentation - where Suzanne Ryan-Ibarra shared the Core Metrics LiveStories site. We asked each of the participants to prioritize Core Metrics indicators that might be useful in their Impact Monterey work, by putting a mark on each of the indicators they think are essential to creating health in Monterey County.




Next, Suzanne Ryan-Ibarra shared the LiveStories website on Safety, the 5th domain area that was prioritized during the first Monterey Convening. We then asked the participants to dialogue in triads on the question: how might we use these tools (Core Metrics and LiveStories) to drive action in Safety (and other priority areas) in Monterey?




In the next phase of the engagement, participants identified potential champions for initiatives/collaborations on a board, so Krista Hanni could reach out to them to see if they might be interested in becoming champions and helping to drive action in Impact Monterey priority areas.


Champion Board
ECONOMIC SELF-SUFFICIENCY
Steinbeck Innovation Cluster
Ag Technology
Monterey Bay Economic Partnership
EDUCATION
Bright Futures (cradle to career)
Bright Beginnings (early childhood)
North Monterey County Community Alliance (cradle to career)
HARTNELL
EAST CANYON'S
JEAN
HEALTH
Monterey County LGBTQI Collab.
Health In All Policies
Regional Diabetes Collaborative
Nutrition and Fitness Collaborative of the Central Coast
Monterey County Collaborates (tobacco control & youth health)
Monterey County Caring Partners (special needs children providers)
Collaborative of Perinatal Services Providers
12 Coalition
Building Healthy Communities (Community empowerment in East Salinas)
Monterey/San Benito County Coalition of Homeless Service Providers
Monterey Salinas Healthcare Collaborative (diabetes Centers + providers)
Monterey County HIV Planning Group
Girls' Health In Girls' Hands (girl leadership development)
SAFETY
DSS - Roadmap to Well-Being
Monterey County Gang Violence Prevention Initiative
Community Alliance For Safety + Peace
4 Cities For Peace
STRYVE
School Climate Transformation Leadership Team (MCOE)
GAP: No Collaborative around recent prison/jail releases + AB109 resources, PAROLE, PROBATION
CCP - AB109 + 1170(h)

Last, we did a written assessment on the convening, asking: what they think the utility of this would be for other locations, what was useful, what not, was it a good use of their time, what could we have done better? As well as any advice for replication?

We closed our time by reflecting what it was like to have worked together and how they felt leaving this final engagement.

## Appendix 9: Scope of Work for Each Community-Based Site

Core Metrics Project Scope of Work (SOW)

Funding Period: April 1, 2016 – December 30, 2016
First payment $8,333.33 delivered after accomplishing:

- Identify and maintain a central point of contact between PHI and site for the duration of the project
- Provide names of coalition or collaborative members, and assist with connection including recruitment for stakeholder interviews and in-person convenings

Second payment $8,333.33 delivered after accomplishing:

- Identify and secure meeting space for the two convenings
- Provide food for convening (total of 2 convenings), Aligned and TBD as both parties mutually agree to date
- Share local data sources for inclusion on the custom website of Core Metrics built using LiveStories
- Assign a representative to support PHI with acquisition of local data sources and provide feedback on the custom website built using LiveStories

Third payment $8,333.33 delivered after accomplishing:

- Complete two convenings with stakeholders
- Provide feedback on final LiveStories website

Ongoing responsibilities:

- Assist with and facilitate logistics for project related work

## Appendix 10: Continuation Activities Funded by Project Extension

The Blue Shield of California Foundation funded the following continuation activities during the period of March 2017 through February 2018 to support additional work related to the Core Metrics Pilot Project. These activities focused on supporting the work of the California Accountable Communities of Health Initiative's (CACHI) Accelerator Sites and lifting up our work on this pilot project via a manuscript in a peer-reviewed journal.

1. An Excel file containing county-level data on the available Core Metrics priority indicators (14 of the 15) was compiled, cleaned, and provided to each of the nine CACHI Accelerator sites:

   Boyle Heights ACH – Los Angeles County
   Humboldt County Health Trust – Humboldt County
   Healthy San Gabriel Valley Initiative – San Gabriel County
   All Children Thrive – Los Angeles County
   Live Healthy Napa County – Napa County
   Hope Rising – Lake County
   Riverside County ACH Coalition – Riverside County
   Fresno Community Health Improvement Partnership – Fresno County
   Sacramento ACH Initiative – Yolo County

2. A crosswalk to analyze similarities and differences of three indicator sets in California: Let's Get Healthy California,[29] California County Health Profiles,[30] and Core Metrics was created. This crosswalk was shared via webinar with the CACHI Accelerator sites in February 2018 (Alignment of measures: Appendix 11).

3. A webinar was conducted on February 13, 2018 with representatives from the CACHI Accelerator sites to describe the Core Metrics as a potential tool that can be used to track progress in population health, care quality, care cost, and engagement over time and the existing public-use datasets that can be used to gather data on the Core Metrics indicators.

4. "Core Metrics Pilot Project: A Case Study" was published as an open-access, peer-reviewed article in *Journal of Public Health Management and Practice* on November 6, 2017. Available here.

[29] More information on the Let's Get Healthy California indicators is available here: http://www.chhs.ca.gov/LGHC/___Let%27s%20Get%20Healthy%20California%20Task%20Force%20Final%20Report.pdf

[30] More information on the California County Health Profiles indicators is available here: https://archive.cdph.ca.gov/programs/ohir/Documents/OHIRProfiles2017.pdf

## Appendix 11: Crosswalk of Core Metrics, Let's Get Healthy California, and California County Health Profiles Measures

| Alignment Across Vital Signs Core Metrics, Let's Get Healthy California, and California County Health Profiles | | | | |
|---|---|---|---|---|
| **Core Metric Domain Areas** | **Let's Get Healthy Measure Area** | **Vital Signs Core Metrics** (Best Current Measure BOLDED) | **Let's Get Healthy California** | **California County Health Profiles** |
| Healthy People | Vaccinations | **Percentage of Children Entering Kindergarten Who Have Received All Recommended Doses** | Doses Of Vaccines For Children 19-35 Months | |
| Care Quality | Redesigning the Health System | | Percent Of Patients Whose Doctor'S Office Helps Coordinate Their Care With Other Providers/Services | |
| Care Quality | Redesigning the Health System | | 30 Day All-Cause Unplanned Readmission Rate | |
| Engaged People | Redesigning the Health System | | Percent Of Patients Who Had Difficulty Finding A Provider Who Would Accept New Patients (Primary Care, Specialty Care Including Mental Health Specialists) (No Indicator Developed) | |
| Engaged People | Redesigning the Health System | | Linguistic And Cultural Engagement (No Indicator Developed) | |
| Care Quality | Redesigning the Health System | | Sepsis-Related Mortality (No Indicator Developed) | |
| Care Quality | Preventable Hospitalizations | **AHRQ** | Dartmouth Atlas - Preventable Hospitalizations (LGH defined as: Redesigning The Health System) | |
| Healthy People | Population Health | Childhood Poverty Rate | | Persons Under 18 In Poverty |

| Alignment Across Vital Signs Core Metrics, Let's Get Healthy California, and California County Health Profiles | | | | |
|---|---|---|---|---|
| **Core Metric Domain Areas** | **Let's Get Healthy Measure Area** | **Vital Signs Core Metrics** (Best Current Measure BOLDED) | **Let's Get Healthy California** | **California County Health Profiles** |
| Care Quality | Patients Receiving Timely Care | **Unmet Care Need (defined as: Self-Reported Getting Needed Care (CAHPS))** | Number Of Primary Care Physicians And Specialists | |
| Healthy People | Obesity | **BMI >= 30 kg/m2 Adults** | BMI >= 30 kg/m2 Adults | |
| Healthy People | Natality | | | Low Birthweight |
| Healthy People | Natality | **Teen Pregnancy Rate** | | Teen Birth Rate |
| Healthy People | Natality | | | Prenatal Care During First Trimester |
| Healthy People | Natality | | | Adequate Prenatal Care |
| Healthy People | Natality | | | Breastfeeding Initiation |
| Healthy People | Mortality | | | All Cause Death |
| Healthy People | Mortality | | | All Cancer Death |
| Healthy People | Mortality | | | Colorectal Cancer |
| Healthy People | Mortality | | | Lung Cancer |
| Healthy People | Mortality | | | Female Breast Cancer |
| Healthy People | Mortality | | | Prostate Cancer |
| Healthy People | Mortality | | | Diabetes |

| Alignment Across Vital Signs Core Metrics, Let's Get Healthy California, and California County Health Profiles | | | | |
|---|---|---|---|---|
| **Core Metric Domain Areas** | **Let's Get Healthy Measure Area** | **Vital Signs Core Metrics** (Best Current Measure BOLDED) | **Let's Get Healthy California** | **California County Health Profiles** |
| Healthy People | Mortality | | | Alzheimer'S Disease |
| Healthy People | Mortality | | | Coronary Heart Disease |
| Healthy People | Mortality | | | Cerebrovascular Disease (Stroke) |
| Healthy People | Mortality | | | Influenza/Pneumonia |
| Healthy People | Mortality | | | Chronic Lower Respiratory Disease |
| Healthy People | Mortality | | | Chronic Liver Disease And Cirrhosis |
| Healthy People | Mortality | Injury Mortality | | Accidents (Unintentional Injuries) |
| Healthy People | Mortality | Injury Mortality | | Motor Vehicle Traffic Crashes |
| Healthy People | Mortality | | | Suicide |
| Healthy People | Mortality | Violence Mortality | | Homicide |
| Healthy People | Mortality | Violence Mortality | | Firearm-Related Deaths |
| Healthy People | Mortality | Infant Mortality | Infant Mortality (LGH defined as: Healthy Beginnings) | Infant Mortality |
| Healthy People | Morbidity | | | Aids |
| Healthy People | Morbidity | | | Chlamydia |

| Alignment Across Vital Signs Core Metrics, Let's Get Healthy California, and California County Health Profiles | | | | |
|---|---|---|---|---|
| **Core Metric Domain Areas** | **Let's Get Healthy Measure Area** | **Vital Signs Core Metrics** (Best Current Measure BOLDED) | **Let's Get Healthy California** | **California County Health Profiles** |
| Healthy People | Morbidity | | | Gonorrhea |
| Healthy People | Morbidity | | | Tuberculosis |
| Care Cost | Lowering the Cost of Care | | Uninsurance Rate | |
| Care Cost | Lowering the Cost of Care | Healthcare Spending Growth | Compound Annual Growth Rate By Total Health Expenditures And Per Capita Costs. | |
| Care Cost | Lowering the Cost of Care | | High Numbers Of People In Population Managed Health Plans | |
| Care Cost | Lowering the Cost of Care | | Transparent Information On Both The Cost And Quality Of Care (No Indicator Developed) | |
| Care Cost | Lowering the Cost of Care | | Most Care Is Supported By Payments That Reward Value (No Indicator Developed) | |
| Healthy People | Livng Well | Activity Levels | Proportion Of Adults Who Meet Physical Activity Guielines For Aerobic Physical Activity | |
| Healthy People | Livng Well | Healthy Eating Patterns | Adults Who Drank 2 Or More Sodas Or Other Sugary Drinks Per Day | |
| Healthy People | Livng Well | Healthy Eating Patterns | Adults Who Have Consumed Fruits And Vegetables 5 Or More Times Per Day | |
| Healthy People | Livng Well | Tobacco Use | Proportion Of Adults Who Are Current Smokers | |

| Alignment Across Vital Signs Core Metrics, Let's Get Healthy California, and California County Health Profiles | | | | |
|---|---|---|---|---|
| **Core Metric Domain Areas** | **Let's Get Healthy Measure Area** | **Vital Signs Core Metrics** (Best Current Measure BOLDED) | **Let's Get Healthy California** | **California County Health Profiles** |
| Care Quality | Livng Well | Hypertension Control | Percent Of Adults Diagnosed With Hypertension Who Have Controlled High Blood Pressure | |
| Care Quality | Livng Well | | Percent Of Adults Diagnosed With High Cholesterol Who Are Managing The Condition | |
| Care Quality | Livng Well | | Prevalence Of Diagnosed Diabetes | |
| Healthy People | Livng Well | Depression | Proportion Of Adolescents And Adults Who Experience A Major Depressive Episode | |
| Healthy People | Livng Well | Depression | Effectively Treating Depression (No Indicator Developed) | |
| Care Quality | Hospital-acquired Infections | **Incidence Per Hospital** | Incidence Per Hospital (LGH defined as: Redesigning The Health System) | |
| Healthy People | Heatlhy People | Contraceptive Use | | |
| Healthy People | Healthy People | Maternal Mortality | | |
| Healthy People | Healthy People | **Life Expectancy At Birth** | | |
| Healthy People | Healthy People | Drinking Water Quality Index | | |
| Healthy People | Healthy People | Air Quality Index | | |
| Healthy People | Healthy People | Drug Dependence/Misuse | | |

| Alignment Across Vital Signs Core Metrics, Let's Get Healthy California, and California County Health Profiles | | | | |
|---|---|---|---|---|
| **Core Metric Domain Areas** | **Let's Get Healthy Measure Area** | **Vital Signs Core Metrics** (Best Current Measure BOLDED) | **Let's Get Healthy California** | **California County Health Profiles** |
| Healthy People | Healthy People | Alcohol Dependence/Misuse | | |
| Healthy People | Healthy Beginnings | | Adverse Childhood Experiences | |
| Healthy People | Healthy Beginnings | | Nonfatal Child Maltreatment | |
| Healthy People | Healthy Beginnings | Childhood Asthma | Emergency Department Visits Due To Asthma | |
| Healthy People | Healthy Beginnings | Activity Levels | Percentage Of Physically Fit Children (Fitnessgram) | |
| Healthy People | Healthy Beginnings | Activity Levels | Proportion Of Adolescents Who Meet Physical Activity Guidelines For Aerobic Physical Activity | |
| Healthy People | Healthy Beginnings | Healthy Eating Patterns | Adolescents Who Drank 2 Or More Glasses Of Soda Or Other Sugary Drink Yesterday | |
| Healthy People | Healthy Beginnings | Healthy Eating Patterns | Adolescents Who Have Consumed Fruits And Vegetables 5 Or More Times Per Day | |
| Healthy People | Healthy Beginnings | | Proportion Of Children And Adolescents Who Are Obese Or Overweight | |
| Healthy People | Healthy Beginnings | Tobacco Use | Proportion Of Adolescents Who Smoked Cigarettes In The Past 30 Days | |
| Healthy People | Healthy Beginnings | | Frequency Of Sad Or Hopeless Feelings In Past 12 Months (Adolescents) | |

| Alignment Across Vital Signs Core Metrics, Let's Get Healthy California, and California County Health Profiles | | | | |
|---|---|---|---|---|
| **Core Metric Domain Areas** | **Let's Get Healthy Measure Area** | **Vital Signs Core Metrics** (Best Current Measure BOLDED) | **Let's Get Healthy California** | **California County Health Profiles** |
| Healthy People | Healthy Beginnings | | School Readiness (No Indicator Developed) | |
| Healthy People | Healthy Beginnings | | Prevalence Of Diagnosed Diabetes In Adolescents (No Indicator Developed) | |
| Engaged People | Health Status | **Self-Reported Health** | Self-Reported Health (LGH defined as: Living Well) | |
| Engaged People | Engaged People | Involvement In Health Initiatives | | |
| Engaged People | Engaged People | Community Health Benefit Agenda | | |
| Engaged People | Engaged People | **Health Literacy Rate (Voter Turnout; English-Language Literacy)** | | |
| Engaged People | Engaged People | **Social Support (Adults Who Met With Others About Community Problems)** | | |
| Care Quality | End-of-Life | | Terminal Hospital Stays That Include Icu Days | |
| Care Quality | End-of-Life | | Percent Of Ca Hospitals Providing In-Patient Palliative Care | |
| Care Quality | End-of-Life | | Hospice Enrollment Rate | |
| Care Quality | End-of-Life | End-Of-Life/Advanced Care Planning | Advanced Care Planning (No Indicator Developed) | |
| Healthy People | Education | **High School Graduate Rate** | Proportion Of Third Graders Who Read At Or Above Proficiency Level | |

| Alignment Across Vital Signs Core Metrics, Let's Get Healthy California, and California County Health Profiles | | | | |
|---|---|---|---|---|
| **Core Metric Domain Areas** | **Let's Get Healthy Measure Area** | **Vital Signs Core Metrics** (Best Current Measure BOLDED) | **Let's Get Healthy California** | **California County Health Profiles** |
| Healthy People | Drug-induced mortality | **Addiction Death Rate** | | Drug-Induced Death Rate |
| Healthy People | Creating healthy communities | Availability Of Healthy Food | Number Of Healthy Food Outlets As Measured By Retail Food Environment Index | |
| Healthy People | Creating Healthy Communities | Walkability | Annual Number Of Walk Trips Per Capita | |
| Healthy People | Creating Healthy Communities | | Percentage Of Children Walk/Bike/Skate To School | |
| Engaged People | Creating Healthy Communities | | Percent Of Adults Who Report They Feel Safe In Their Neighborhoods All Or Most Of The Time | |
| Care Quality | Care Quality | Influenza Immunization | | |
| Care Quality | Care Quality | Colorectal Cancer Screening | | |
| Care Quality | Care Quality | Breast Cancer Screening | | |
| Care Quality | Care Quality | Usual Source Of Care | | |
| Care Quality | Care Quality | Wrong-Site Surgery | | |
| Care Quality | Care Quality | Pressure Ulcers | | |
| Care Quality | Care Quality | Medication Reconciliation | | |
| Care Quality | Care Quality | Diabetes Care Composite | | |

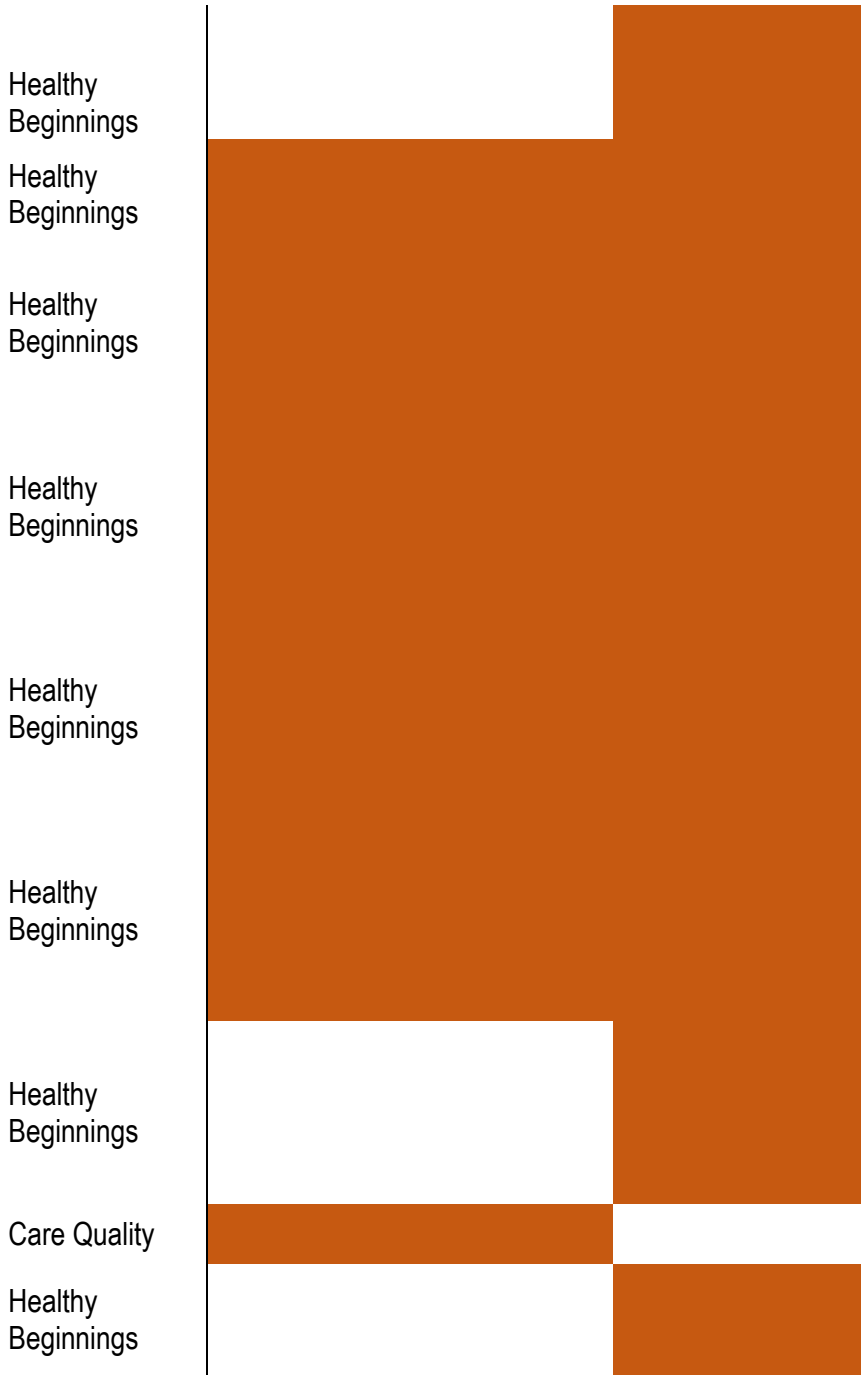
| Alignment Across Vital Signs Core Metrics, Let's Get Healthy California, and California County Health Profiles | | | | |
|---|---|---|---|---|
| **Core Metric Domain Areas** | **Let's Get Healthy Measure Area** | **Vital Signs Core Metrics** (Best Current Measure BOLDED) | **Let's Get Healthy California** | **California County Health Profiles** |
| Care Quality | Care Quality | Heart Attack Therapy Protocol | | |
| Care Quality | Care Quality | Stroke Therapy Protocol | | |
| Care Quality | Care Quality | Unnecessary Care Composite | | |
| Care Quality | Care Quality | Patient Experience | | |
| Care Quality | Care Quality | Shared Decision Making | | |
| Care Quality | Care Quality | **Patient Clinician Communication Satisfaction** | | |
| Care Cost | Care Cost | Per Capita Expenditures For Medi-Cal And Reimbursements For Medicare Enrollees | Health Care Cost As Percentage Of Median Household Income (LGH defined as: Lowering The Cost Of Care) | |
| Care Cost | Care Cost | Healthcare Related Bankruptcies | | |
| Care Cost | Care Cost | Total Cost Of Care | | |
| Care Cost | Care Cost | **High Spending Relative To Income** | | |

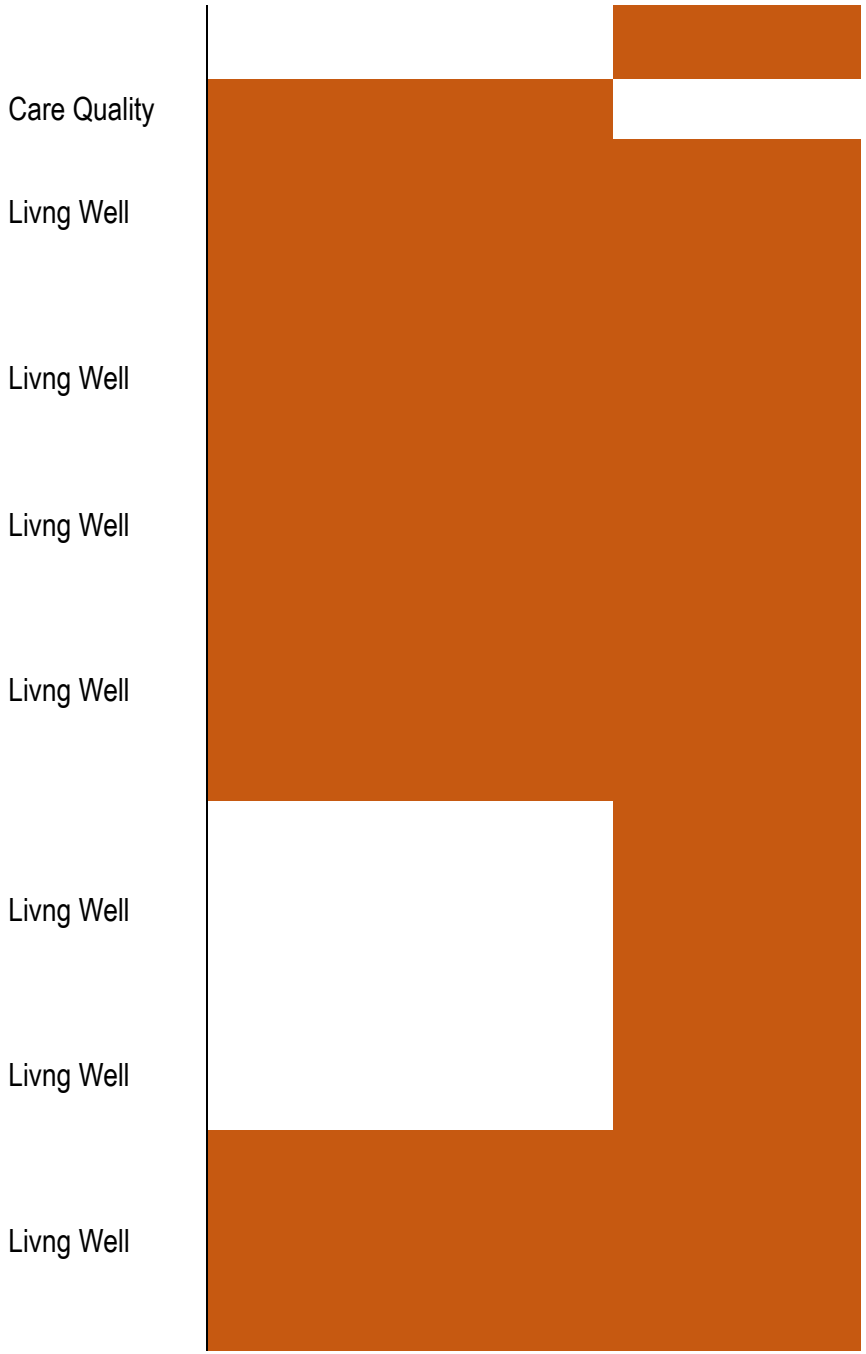
**Alignment Across Vital Signs Core Metrics, Let's Get Healthy California, and California County Health Profiles**

| **Measure Area** | **Vital Signs Core Metrics** (Best Current Measure **BOLDED**) | **Let's Get Healthy California** | **California County Health Profiles** |
|---|---|---|---|


Vaccinations
Care cost
Care cost
Care Cost
Care Quality
Care Quality
Care Quality
Care Quality
Care Quality
Mortality
Mortality
Mortality
Mortality
Mortality
Mortality
Mortality
Mortality
Mortality
Mortality

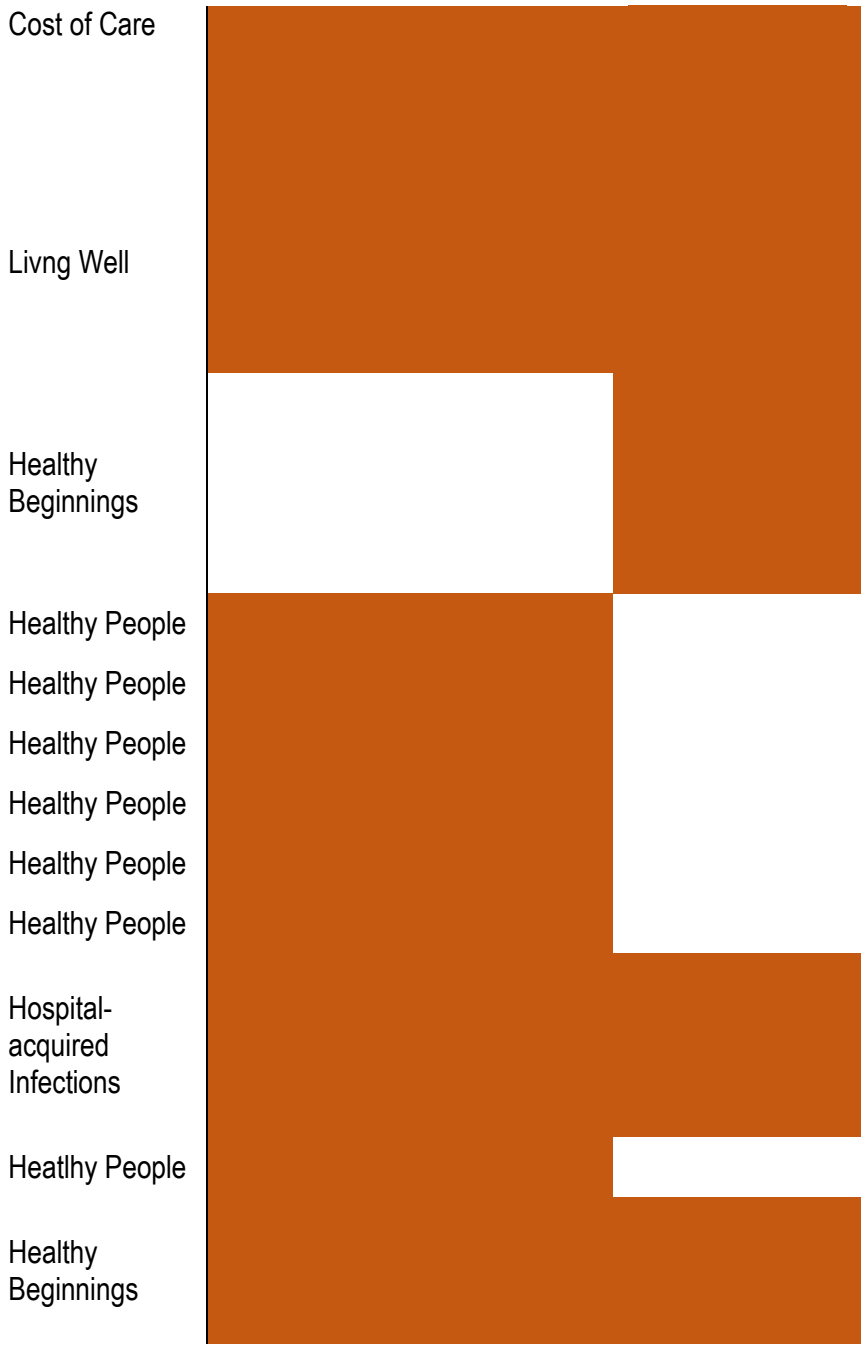

Mortality
Mortality
Mortality
Mortality
Mortality
Mortality
Mortality
Morbidity
Morbidity
Morbidity
Morbidity
Care Quality
Natality
Care Quality
Natality
Natality
Natality
Care Quality
Healthy Beginnings

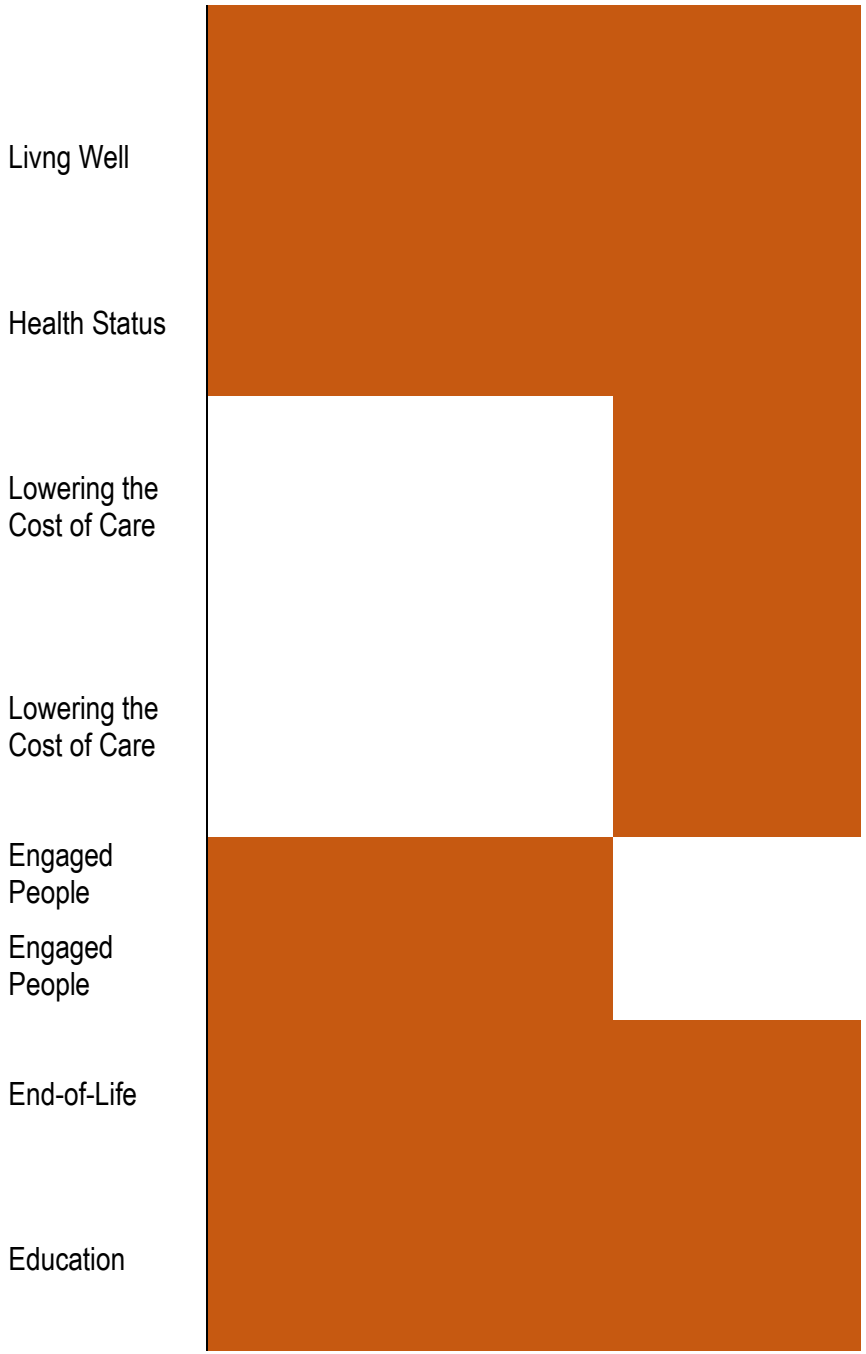

Healthy Beginnings
Healthy Beginnings
Healthy Beginnings
Healthy Beginnings
Healthy Beginnings
Healthy Beginnings
Care Quality
Healthy Beginnings

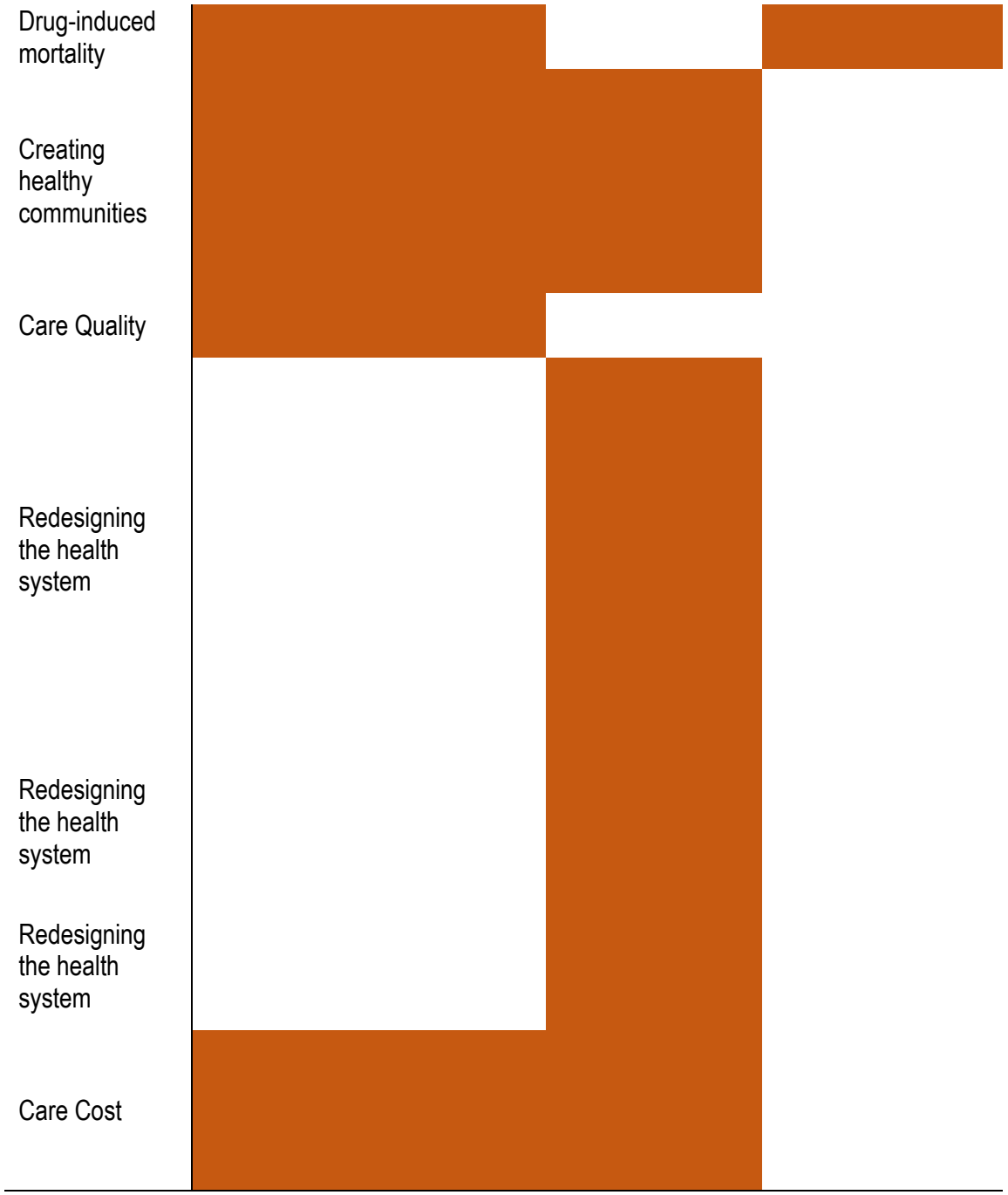

Care Quality
Livng Well
Livng Well
Livng Well
Livng Well
Livng Well
Livng Well
Livng Well


Care Quality
End-of-Life
End-of-Life
Redesigning the health system
Care Quality
Care Quality
Creating healthy communities
Creating healthy communities
Creating healthy communities
Lowering the Cost of Care
Redesigning the Health System


Lowering the Cost of Care
Healthy Beginnings
Preventable Hospitalizations
Population health
Patients Receiving Timely Care
End-of-Life
Obesity
Natality
Engaged People
Engaged People
Mortality
Lowering the


Cost of Care
Livng Well
Healthy Beginnings
Healthy People
Healthy People
Healthy People
Healthy People
Healthy People
Healthy People
Hospital-acquired Infections
Heatlhy People
Healthy Beginnings


Livng Well
Health Status
Lowering the Cost of Care
Lowering the Cost of Care
Engaged People
Engaged People
End-of-Life
Education


Drug-induced mortality
Creating healthy communities
Care Quality
Redesigning the health system
Redesigning the health system
Redesigning the health system
Care Cost