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Evaluating State Flex Program Population Health Activities

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KEY FINDINGS

- Population health is an important area of State Flex Program (SFP) activity that can align with and support the accountability requirements of tax-exempt Critical Access Hospitals (CAHs).
- SFP population health initiatives involving collaborative learning activities and coherent strategies moving from assessment to implementation across the funding cycle have the greatest potential to improve the health of their communities.
- The Population Health Program Area provides an opportunity to align with the U.S. Department of Health and Human Services' Healthy Rural Hometown Initiative (HRHI) to address disparities underlying the five leading causes of death in rural areas.
- Evidence-based population health strategies targeting the needs of vulnerable rural populations can contribute to improvements in health equity.

PURPOSE

The Medicare Rural Hospital Flexibility (Flex) Program funds initiatives to improve the health of rural communities under Program Area 3: Population Health Improvement. The goal of this optional Flex Program Area is to build the capacity of Critical Access Hospitals (CAHs) to achieve measurable improvements in the health outcomes of their communities.[1-2] This brief: (a) provides an overview of the expectations for Program Area 3; (b) summarizes State Flex Program (SFP) initiatives under this Program Area; (c) describes promising population health strategies implemented by SFPs; and (d) discusses outcome measurement issues for population health. It also describes a pathway to connect Flex Program population health efforts to the U.S. Department of Health and Human Services' Healthy Rural Hometown Initiative (HRHI), a five-year multi-program effort to address the factors driving rural disparities in heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke.[3] A companion brief, *An Inventory of State Flex Program Population Health Initiatives for Fiscal Years 2019-2023*, provides a detailed description of population health initiatives proposed by the 45 SFPs.

BACKGROUND

SFPs are encouraged to engage CAHs in population health initiatives, including chronic care management, clinical care coordination, and collaborative community programs to address the social determinants of health and the unmet specific health care needs of their local community. SFPs may propose initiatives in one or more of the three optional population health activity categories:[2]

3.1 Support to assist CAHs in identifying community and resource needs includes assessment and planning resources to support CAH population health interventions under Activity Categories 3.2 and 3.3. Suggested activities include encouraging CAHs to complete a Population Health Readiness Assessment (PHRA),[4] using the assessment results to assist them in building capacity, offering community health needs assessment (CHNA) trainings, and evaluating CAH CHNAs and implementation plans prepared to inform planning for population health cohorts.

3.2 Assist CAHs with building strategies to prioritize and address unmet community needs utilizes the results of PHRAs and CHNAs to help CAHs design action plans to address the needs of their communities. Tax-exempt (501(c)(3)) CAHs are required to conduct triennial CHNAs and use the results to implement strategy plans to address priority needs. While publicly owned CAHs are not subject to these requirements, SFPs can encourage them to engage in population health planning and participate in CAH population health cohorts. Suggested activities include sharing resources to inform population health action planning; offering population health education workshops or webinars; facilitating collaboration between CAHs and community stakeholders; and evaluating the progress of action plans.

3.3 Assist CAHs with engaging community and public health stakeholders to respond to the population health needs of their communities. This activity category seeks to build on information collected through CHNAs, implementation plans, and engagement between CAHs, public health leaders, and community stakeholders to address local concerns. Suggested activities include implementing chronic care management programs; substance use prevention, treatment, and recovery strategies; mental health services; and programs to address public health, wellness, and the social determinants of health.

These three activity categories suggest a stepwise process that can be implemented across the five-year funding cycle. Activity Category 3.1 includes planning and assessment activities to support development of CAH population health initiatives (Activity Category 3.2) and implementation of targeted interventions (Activity Category 3.3). Assessment and planning work is best accomplished early in the funding cycle to identify and build on CAH strengths, address CAH weaknesses, and quantify community needs that can be addressed throughout the funding cycle. Although SFPs are not required to implement such an approach, a comprehensive multi-year population health strategy is more likely to improve population health than unconnected initiatives under any one or more activity categories. This brief will highlight examples of SFPs that have adopted this multi-year approach to population health.

APPROACH

We reviewed the FY2019 State Flex Program competitive grant applications to inventory and categorize projects proposed under each activity category under Program Area 3. We also reviewed other Program Areas to identify population health-related initiatives. We further reviewed the FY2020 Non-Competitive Continuing applications and FY2019 End of Year reports to assess the continuation of these activities in 2020, as well as identify any new or revised activities. We summarized the initiatives for each SFP and coded them thematically to identify common activities.

In conducting our initial inventory of SFP population health activities, we originally grouped each activity using the activity category under which it was proposed. As we observed that not all SFPs reported similar activities in the same activity categories, we recategorized activities to group similar activities consistently across the states.

In addition to describing the specific activities proposed by each SFP, we identified the process/output and outcome measures identified by SFPs for their population health activities. Finally, we examined the Notice of Funding Opportunity for the HRHI track of the Rural Health Care Services Outreach Grant

Program to identify opportunities to align Flex Program activities conducted under Program Area 3 with the multi-year HRHI initiative.

RESULTS

Summary of State Health Flex Program Population Health Initiatives

Detailed information on SFP population health activities is available in the supplemental brief for this project, *An Inventory of State Flex Program Population Health Initiatives for Fiscal Years 2019 – 2023*. This section provides a high-level summary of SFP population health activities as described in that brief.

Thirty-one SFPs implemented one or more initiatives under Activity Category 3.1 (Figure 1) with the most common focusing on supporting CAHs in completing CHNAs through trainings, technical assistance (TA), and distribution of community health data; analyzing the CHNAs or other assessments to identify shared issues in the CAH communities and to inform initiatives for Activity Categories 3.2 and 3.3; and encouraging CAHs to take a population health readiness assessment to gauge leadership's understanding of and the hospital's capacity to address population health.

Twenty-four SFPs offered programming to assist CAHs with strategies to prioritize and address unmet needs under Activity Category 3.2. When we included population health-related activities from other program areas and recategorized activities to group similar activities consistently across the states, we found that 34 SFPs implemented this type of initiative (Figure 2). The most common interventions involved training or TA to develop strategies to prioritize and address unmet needs, followed by assistance to CAHs to formalize their strategies into action plans.

Twenty-seven SFPs offered programming to assist CAHs to address specific health needs under Activity Category 3.3. When we included population health-related activities from other program areas and recategorized activities to group similar activities consistently across the states, we found that 34 SFPs implemented this type of initiative (Figure 3). SFPs facilitated collaboration between CAHs and community and population health stakeholders using data summaries and tools, educational opportunities, and engagements with local health authorities, state public health officers, payers, and other stakeholders. They addressed a range of health needs with the most common interventions focused on health and wellness,

FIGURE 1: Assisting CAHs to Identify Community Resources and Needs (n=31 SFPs)

States may use more than one approach to assist CAHs with identifying community resources and needs.

behavioral health, chronic disease management, and the social determinants of health (Figure 3). Nine of the 34 SFPs waited to determine what specific health needs to focus on until after they had worked with their CAHs to assess need and determine priorities.

Promising SFP Population Health Strategies

In reviewing the inventory of SFP population health activities, we observed that SFPs proposed a wide variety of population health activities across the three activity categories. Many focused on providing basic education, technical assistance, and support related to the CHNA process and/or population health readiness assessments. While these activities may be useful to some CAHs, they do not necessarily represent a comprehensive strategy to assist CAHs in implementing evidence-based population health initiatives. It is also difficult to link these activities to demonstrable improvements in population health.

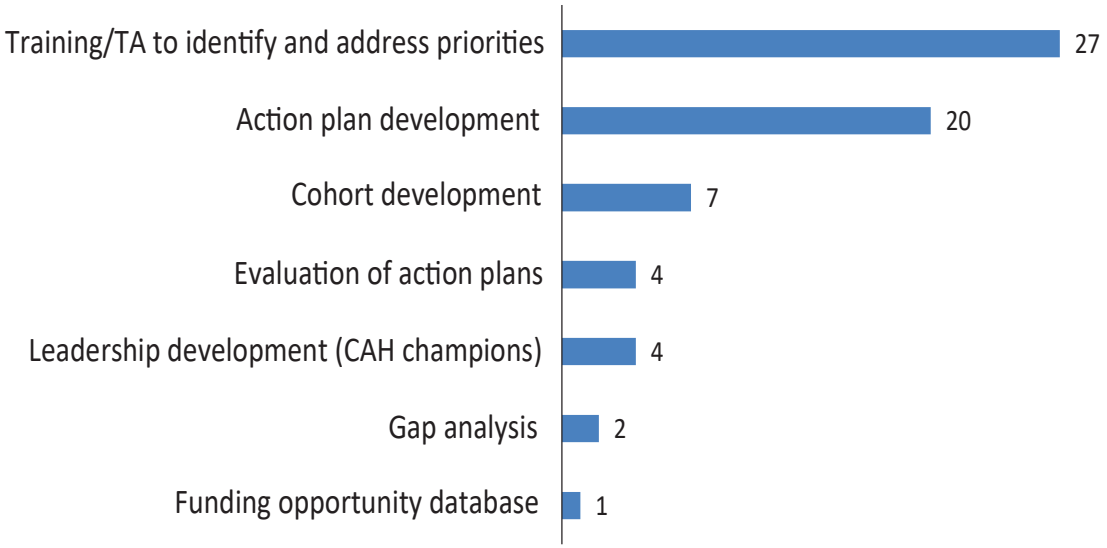
Based on our inventory review, we identified two promising approaches to supporting population health. The first involves engaging CAHs in collaborative learning cohorts focused on addressing commonly identified population health issues. The second involves implementing coordinated strategies across the funding cycle to improve population health.

Minnesota and Colorado provide examples of cohort-based collaborative learning initiatives. Although Arizona's activities are not cohort-based, SFP staff follow a sequential approach to working with their CAHs on population health initiatives across activity categories and the funding cycle.

Minnesota developed two cohort-based initiatives that draw on the population health readiness assessments completed by CAHs in Year One. The first initiative is based on Rural Health Innovations' (RHI) Rural Health Path to Value program[5] with a focus on care coordination to address health outcomes and the social determinants of health. Following completion of the readiness assessment, Minnesota works with cohort CAHs to identify community resources and needs (Year One), develop community partnerships to facilitate collaboration (Years Two and Three), and engage community partners in local projects (Years Four and Five). Under this initiative, cohort members (up to six CAHs) receive TA and site visits from RHI and participate in peer learning.

Minnesota's second initiative focuses on building CAH leadership capacity and community ownership of population health improvement among two cohorts of 10 CAHs each. The first cohort was

FIGURE 2: Assisting CAHs to Build Strategies to Prioritize and Address Unmet Needs (n=34 SFPs)



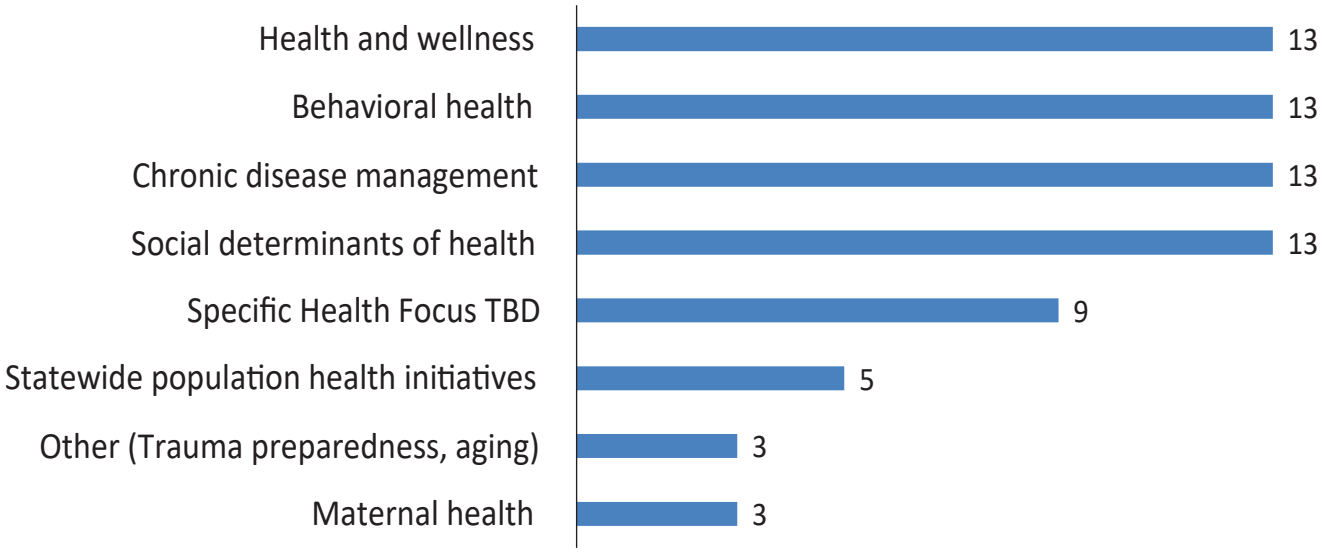
States may report multiple approaches to assisting CAHs with identifying, prioritizing, and addressing unmet needs.

established in Year Two and the second will be established in Year Four. Each cohort is expected to identify priority needs using a population health change package designed by Stratis Health. Cohort members receive TA to implement evidence-based population health interventions. This TA includes facilitation and action planning support and a workshop to train staff and community partners in Leadership and Organizing for Change,[6] a community organizing model promoted by the Institute for Healthcare Improvement. Cohort members receive an assessment based on data from 2019 CHNA results, County Health Rankings, and other local data sources to measure baseline status and track population health improvement.

Colorado works with CAHs to prioritize and address population health needs via a cohort-based chronic care management project called the Colorado Rural Sustainability (CORS) Network. In Year One, CAHs completed the National Rural Health Resource Center's PHRA, and the results were used to identify communities positioned to implement population health projects. In subsequent years, the SFP works with the CORS Network to implement chronic care management programs utilizing peer learning calls, workshops, network meetings, and one-on-one coaching calls. Network members target three National Quality Forum (NQF) measures for long-term improvement: the rate of readmission after discharge from the hospital for all cause readmissions (NQF 1789); the rate of patients with a controlled high blood pressure (NQF 18); and the percent of patients with hemoglobin A1c levels greater than nine percent during the measurement period (NQF 59). Participants submit data monthly via the Quality Health Indicators portal. The Recommendation Adoption Process Model[7] is used to evaluate the progress of each community's action plan.

Arizona's population health program builds from one activity category to another over the course of the funding cycle beginning with a statewide population and community health needs assessment conducted in Year One. To supplement the statewide data, Arizona synthesized the CHNAs from its CAHs to identify common community health needs and align state-level health priorities with community-level needs. In subsequent years, Arizona works with CAHs that request assistance with community health activities and interventions. This work is conducted by two Health Education/Community Outreach Specialists who support CAHs in prioritizing local needs and implementing strategies to address identified needs such as

FIGURE 3: Assisting CAHs to Address Specific Health Needs (n=34 SFPs)



States may report multiple approaches to assisting CAHs with addressing specific health needs.

access to care, behavioral health services, and healthy lifestyle factors (Activity Category 3.2). They also work with CAHs to engage with their communities as part of this work and to evaluate the impact of local population health improvement initiatives (Activity Category 3.3).

Outcome Measurement

We observed several issues related to state efforts to monitor and document the impact of their population health initiatives. One issue was a reliance on process and output measures, particularly for participation in educational activities and completion of interim and milestone project tasks. Another involved confusion between output and outcome measures as demonstrated by the number of states that list output/process measures as outcomes. A final issue involved the selection of outcome measures with a corresponding discussion of data sources to support those measures.

To assess the impact of population health activities, it is necessary to understand the difference between the achievement of significant project milestones (e.g., the completion of CHNAs and related implementation plans) and actual changes in population health (e.g., reductions in unnecessary admissions, increases in the number of patients with controlled blood pressure). While tax-exempt hospitals are required to complete triennial CHNAs and develop implementation plans specifying which identified needs they will address, this doesn't guarantee improved community health. An FMT study on the alignment of CAH CHNAs and implementation plans noted that study CAHs tended to emphasize medical rather than population-level factors affecting the community and, in some cases, emphasized hospital-level facility and/or technology needs.[8] As such, the completion of the CHNAs and implementation plans, while an important project milestone, is not a substantive population health outcome measure. Instead, we recommend that SFPs and CAHs select outcome measures based on activities identified in their implementation plans. As implementation plans must be updated annually, these documents provide ongoing information on the status of the hospital's response to local needs and any changes in hospital activities.

As it is beyond the scope of this brief to identify all possible outcome measures for population health activities, the following provides an example of a chain of short, intermediate, and long-term outcome measures for a diabetic chronic care management and prevention program (Figure 4). Resources to support the measurement of population health improvement initiatives are detailed in the Appendix.

Alignment of Population Health Activities with the Healthy Rural Hometown Initiative

While population health and the development of rural systems of care have long been an integral part of Flex Program activities, the U.S. Department of Health and Human Services (DHHS) has launched a complimentary program, the Healthy Rural Hometown Initiative (HRHI), through its September 2020 Rural Action Plan.[3] The HRHI is a five-year multi-program effort to address the factors that drive rural disparities related to heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke.[9] The goals of the HRHI are to demonstrate the impact of projects that better manage conditions, address risk factors, and focus on prevention related to the leading causes of death in rural communities, and to highlight how rural community health efforts can improve health at the local level.

This initiative has two phases. The first is intended to align and target community-focused funding streams within FORHP to address the underlying factors that affect growing rural disparities related to these five causes of excess death. Beginning in FY2020, the Health Resources and Services Administration (HRSA) began to implement strategies to target approximately 20 percent of its rural community-based programs to focus on these disparities and encourage recipients to include human service providers and state Medicaid stakeholders in their networks to improve health and reduce long-term costs associated with treatment. The second phase will work across additional DHHS entities to leverage other programs

FIGURE 4: Outcome Measures for a Diabetic Chronic Care Management and Prevention Program

Population Health Activity	Short-term Outcome Measures	Intermediate Outcome Measures	Long-term Outcome Measures
Work with CAHs to implement chronic care management (CCM) and prevention programs for diabetes.	• # of diabetic patients registered in CCM • # of pre-diabetic patients registered in prevention program • # of patients receiving diabetic education • # of patients participating in CCM interventions (e.g. keeping blood glucose logs, setting weight goals) • # of patient contacts/interactions • # of patients receiving support in obtaining needed resources (e.g., glucometers, medications, etc.)	• # of patients receiving regular HbA1c testing, eye exams, medical attention for nephropathy • Reduction in the % of pre-diabetic patients developing Type 2 diabetes • Reduction in the # of pre-diabetic patients registered in prevention program • Improvement in the # of patients with control of HbA1c, blood pressure, weight	• Reduction in unnecessary hospital admissions due to complications of diabetes • Reduction in emergency department use due to complications from diabetes • Reduction in # of patients experiencing complications of diabetes (e.g., cataracts, glaucoma, or blindness; nerve damage, amputations, etc.)

and research funding streams as part of this initiative.

Program Area 3 provides an opportunity to align the work of the Flex Program with the goals of the HRHI by encouraging SFPs to focus on conditions and factors underlying the rural disparities that contribute to the higher rates of death for these five conditions. At the same time, efforts to engage CAHs in addressing these issues align well with IRS tax-exempt hospital accountability requirements as described earlier. This is an area of activity ideally suited to cohort-based collaborative learning initiatives that support the implementation of common interventions across groups of CAHs involving shared learning and the reporting of common population health improvement metrics. Nothing in the current program framework for Program Area 3 precludes SFPs from undertaking work that aligns with HRSA's plans to expand the HRHI concept across other programs and funding streams.

Fortunately, a strong body of evidence-based rural intervention models exists to support SFPs and CAHs interested in expanding their population health portfolio by developing programs on chronic disease self-management, care coordination, screening for health risks, tobacco cessation, weight management, prevention, and/or physical activity.

The Rural Health Information Hub provides links to nearly 60 examples of evidence-based chronic care models and innovations that have been successfully

implemented in rural areas.[9] These models include in-person, community-based, and telehealth-based programs to support widespread implementation based on local needs and resources. Some of these models, such as the Vivir Mejor program described below, involve CAHs. Others can be implemented by CAHs and their community partners. Although many of these programs target the general population, a number can improve health equity goals in rural communities by targeting the needs of underserved populations. Examples of these (and other) models include:

- Salud es Vida Cervical Cancer Education – a lay health worker curriculum that provided information on cervical cancer, HPV, and the HPV vaccine to Hispanic farmworker women living in rural southern Georgia and South Carolina

- Vivir Mejor! (Live Better!) System of Diabetes Prevention and Care – a culturally competent diabetes education and prevention program targeting rural Hispanic/Latino populations and involving a partnership of a CAH, a food bank, a university-based prevention research center, an Area Health Education Center, and several other non-profit organizations.

- The Adolescent Pre-Diabetes Prevention Program – a program to prevent type 2 diabetes in adolescents living in rural Louisiana through prescreening for pre-diabetes and education on nutrition and physical activity education in school-based health centers and high schools

- Kentucky Homeplace – a community health worker initiative to address the lifestyle choices, inadequate health insurance, and environmental factors that are believed to contribute to chronic diseases for residents of rural Appalachia

- Steps to Wellness/Pasos Hacía Salud – a community-wide outreach and educational program focused on diabetes reduction and weight management targeting low-income and Spanish-speaking residents of Oregon and Washington's Columbia River Gorge area

- The Traditional Food Project – aimed at reducing rates of type 2 diabetes among American Indian/Alaskan Native populations by improving access to local, traditional foods, and physical activity to promote health

DISCUSSION

SFPs have implemented a wide range of population health activities in the current funding cycle. Based on our inventory and analysis of SFP work in this area, we have identified some key themes that are worth exploring. First and foremost, states have focused heavily on supporting CAHs in conducting their required triennial CHNAs and implementation plans as well as engaging them in completing population health readiness assessments. While these are important foundational activities, they are not sufficient to directly improve population health. In 2021, tax-exempt CAHs (and other hospitals) entered their fourth cycle of required CHNAs since the implementation of this regulatory obligation in 2012 under the Affordable Care Act. Given this fact, SFP population health activity should move beyond focusing on these

assessments alone. Instead, SFPs should work with CAHs to directly address common population health needs identified through the CHNA process as part of an integrated strategy across the funding cycle.

As part of this and other evaluations of Flex Program Areas, we have observed that collaborative learning cohorts can provide a useful structure to support the engagement of CAHs in quality, financial, operational, and population health improvement activities. These collaborative learning cohorts typically involve the implementation of a common intervention by cohort participants, shared learning related to implementation and management of those interventions, and consistent reporting of a standard set of performance metrics by cohort members.

HRSA's Healthy Rural Hometown Initiative provides another opportunity to improve the impact of SFP population health efforts by addressing factors

underlying the five leading causes of death in rural communities. SFPs have an opportunity to align their population health efforts with this important HRSA initiative as well as to support tax-exempt CAHs in fulfilling their obligation to address the needs of their communities through their assessment and implementation planning requirements. The Rural Health Information Hub and other sources have identified evidence-based models that can be used to support work in this area. At the same time, SFPs and CAHs can advance the cause of health equity by implementing programs that address the needs of vulnerable populations in rural communities. SFPs would benefit from technical assistance to support their population health activities and align their work with the HRSA's Healthy Rural Hometown Initiative.

SFPs would also benefit from a better understanding of the differences between output and outcome measurement to create a chain of evidence to document the impact of their efforts. This will involve the identification of short-, intermediate-, and long-term outcomes measures that connect activities to desired high-level goals and outcomes. At the same time, it is difficult for SFPs to identify short- and intermediate-term outcome measures before participating CAHs have had an opportunity to identify their specific population health interventions. As population health interventions are developed and implemented, SFPs should update their outcome monitoring strategies and work plans to incorporate short- and intermediate-term measures appropriate to their specific intervention activities and goals.

CONCLUSIONS

Program Area 3: Population Health Improvement remains an important area of Flex Program activity and an opportunity for SFPs to work with their CAHs to improve population health and health equity. Moving forward, we encourage SFPs to use population health readiness and community health needs assessments as a foundation for population health activity across the funding cycle, rather than as standalone activities. This foundation can be used to support more substantive activities that can directly impact and improve the population health of rural communities as well as address the needs of underserved rural populations across the Flex Program funding cycle. We further encourage SFPs to explore the use of collaborative learning cohorts to undertake population health initiatives.

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APPENDIX. POPULATION HEALTH MEASURES

Source	Resource description
Selecting Population Health Measures	
Centers for Medicare & Medicaid Services (CMS)	*Population Health Measures: Supplemental Material to CMS MMS Blueprint*. A high-level overview and definition of population health measures.
National Quality Forum (NQF)	*Improving Population Health by Working with Communities-Action Guide 3.0.* A comprehensive framework to help multi-sector groups improve population health by addressing 10 key elements. Element 7 includes selection and use of measures and performance targets.
Stoto, Michael (2014)	*Population Health Measurement: Applying Performance Measurement Concepts in Population Health Settings.* This paper discusses the role CHNAs can play in identifying goals and objectives of population health measurement, which aspects of population health to measure, how to measure those aspects of population health, and the validity and reliability of population health measures.
Population Health Measures and Data Sets	
County Health Rankings and Roadmaps	*2021 County Health Rankings Measures*. Areas covered include health outcomes and health factors such as health behavior, clinical care, social and economic factors, and physical environment.
Healthy People 2030	*Healthy People 2030 Objectives.* Provides measurable objectives, baseline data, and target rates for improvement for health conditions, health behaviors, populations, settings, systems, and social determinants of health.
Gale, J; Hansen, A; Hartley, D; Coburn, A. (2016)	*Pilot Testing a Rural Health Clinic Quality Measurement Reporting System*. This study identifies measures that rural health clinics found valuable including diabetes hemoglobin A1c control, controlling high blood pressure, documentation of current medications, tobacco use cessation intervention and childhood immunization status. The researchers discuss challenges RHCs faced with collection, extraction, and reporting of the measures.
National Quality Forum (NQF)	*A Core Set of Rural-Relevant Measures and Improving Access to Care: 2018 Recommendations from the MAP Rural Health Workgroup.* The Workgroup proposed measures are NQF-endorsed, cross-cutting, resistant to low case-volume, and address transitions in care. The Workgroup also agreed on the potential inclusion of measures that address mental health, substance abuse, medication reconciliation, diabetes, hypertension, chronic obstructive pulmonary disease, hospital readmissions, perinatal conditions, and the pediatric population.
Diabetes Prevention and/or Management Measures	
Centers for Disease Control and Prevention (CDC)	*Health Outcomes/Diabetes Evaluation Measures.* This webpage provides process and outcome measures for type 2 diabetes prevention and control programs.
Centers for Disease Control and Prevention (CDC)	CDC Diabetes Prevention and Recognition Program: Standard and Operating Procedures outlines the criteria that must be met to receive full recognition through the CDC Diabetes Prevention Recognition Program (DPRP). B.) *Keys to Success* provides a quick reference to the measures required for DPRP recognition.

Source (cont'd)	Resource description (cont'd)
Centers for Medicare & Medicaid Services (CMS)	*Diabetes Prevention Programs: Equity Tailored Resources.* An evidence-based, lifestyle intervention with 16 sets of culturally and linguistically tailored materials and related outcome measures. This resource may be helpful in supplementing a CDC-approved curriculum.
Hypertension Prevention and/or Management Measures	
Centers for Disease Control and Prevention (CDC)	*Health Outcomes/Blood Pressure Evaluation Measures.* As part of the CDC's workplace health strategies, this module discusses potential baseline, process, and outcome measures for employee hypertension prevention and management programs.
Sadeghi, C; Khan, HA; Dudleski, G; Reynolds, JL; and Bakhai, SY. (2020)	*Multifaceted strategies to improve blood pressure control in a primary care clinic: A quality improvement project*. This paper describes the process and outcome measures used for a clinic-based blood pressure control project.
Social Determinants of Health Measures	
Centers for Disease Control and Prevention (CDC)	*Data Set Directory of SDOH at the Local Level.* The directory contains an extensive list of existing data sets that can be used to address SDOH. The data sets are organized according to 12 broad categories of the social environment.
National Association of County & City Health Officials	*Community Health Assessments and Community Health Improvement Plans for Accreditation Preparation Demonstration Project: Resources for SDOH Indicators.* Offers a list of data sources for SDOH.
Rural Health Information Hub	*Module 5: Evaluation Considerations for Social Determinants of Health Programs* is part of the *SDOH in Rural Communities Toolkit*. *Module 5* offer sample measures for five domains (economic stability, education, health and healthcare, neighborhood and built environment, and social and community context) plus one for cross-cutting disciplines.
Substance Use Disorder Prevention and/or Management Measures	
Centers for Disease Control and Prevention (CDC)	*Health Outcomes/Diabetes Evaluation Measures.* This webpage provides process and outcome measures for type 2 diabetes prevention and control programs.
Rural Health Information Hub	*The Evaluation Measures* module in the *Rural Prevention and Treatment of Substance Use Disorders Toolkit* provides potential process and outcomes measures to consider when assisting CAHs in evaluating a SUD prevention or treatment initiative and when determining appropriate outcome measures for cohort related SFP initiatives around SUD.