EXEMPLARS OF COMMUNITY HEALTH NEEDS ASSESSMENT COLLABORATION

CONTEXT

The quantity and quality of collaborations between hospitals and local public health agencies across the nation have been encouraged or facilitated by two developments. First, the Internal Revenue Code 501(r)(3) requires non-profit hospitals to conduct a Community Health Needs Assessment (CHNA) every 3 years and to adopt an implementation strategy to meet the community needs identified (IRS, 2014). Second, local health departments (LHDs) have the incentive to collaborate with hospitals when seeking accreditation from the Public Health Accreditation Board, a process that requires the completion of a community health assessment (PHAB, 2014).

The collaboration between local public health agencies and hospitals has the potential to materialize into a focus on population health improvement, better coordination of care, and cost savings. The quality and extent of CHNA-related collaboration between these entities range from communication to integrated action. On the hospital side, factors that have been found to influence collaboration include (1) delivery system reform participation (e.g., in an accountable care organization), (2) state requirements, and (3) the status of the social determinants of health in the communities where the hospitals are located (Cramer et al., 2017). On the LHD side, characteristics that influence collaboration are LHD size, governance structures (e.g., local board of health), and expenditures (Beatty et al., 2015).

In recognition of the investments and efforts that both local public health agencies and hospitals must make to collaborate, the Action Collaborative on Bridging Health, Health Care, and Community sought to surface some CHNA-related collaboration examples through a call for abstracts. From the submissions, subject matter experts (SMEs) selected instances of collaboration that are of exemplary quality.

To make their decision, SMEs assessed the levels of joint action, the extent of the collaboration articulated in the abstracts, and the uniqueness of the collaboration. The National Association of City and County Health Officials (NACCHO) has defined the levels of joint action, starting at the basic level of *networking* (exchanging information), *coordination* (exchanging information and linking existing activities for mutual benefit), *cooperation* (sharing resources for mutual benefit to create something new), and finally *collaboration* (working jointly to accomplish shared vision and mission using joint resources). Beatty et al. (2015) previously used the framework to characterize the level of joint action among 34 non-profit hospitals and LHDs using Missouri hospitals' CHNAs and found that only 3% of hospitals were engaging in collaboration.

We thank everyone who submitted an abstract as they lent insight into some of the different CHNA-related collaboration arrangements that exist in communities around the country. The accounts featured on the following pages show a range of collaborations—from regional-based collaboration, to state-level coordination, multi-stakeholder partnerships, and simple yet successful efforts.

This piece was developed by the Action Collaborative on Bridging Public Health, Health Care and Community, an ad hoc activity associated with the Roundtable on Population Health Improvement at the National Academies of Sciences, Engineering, and Medicine (the National Academies). The piece does not necessarily represent the views of any one organization, the Roundtable on Population Health Improvement, or the National Academies and has not been subjected to the review procedures of, nor is it a report or product of, the National Academies.

MESSAGE FROM THE COLLABORATIVE CO-CHAIRS

We would like to extend our sincere appreciation and thanks to everyone who submitted an abstract for consideration in this project. We recognize that your submittals demonstrate the important work of bridging medicine and public health in your communities. They required the commitment of valuable time and effort of already overstretched health departments and the limited staff dedicated to Community Health Needs Assessment (CHNA) related activities. We would like to thank those featured in this piece for their willingness to develop their stories and their patience throughout the production process. Furthermore, we are grateful to colleagues of the authors who contributed to both the submission of these accounts and to the CHNA collaborations themselves.

We also would like to thank those who informed the process of our call for abstracts:

- Mary Davis, Si Texas Senior Evaluation Lead, Research & Evaluation at Health Resources in Action
- Mike Stoto, PhD, Professor of Health Systems Administration and Population Health at Georgetown University.
- Sue Grinnell, MPH, Director of Business Strategy and Technology at Public Health Institute's Population Health Innovation Lab and;
- Kevin Barnett, Senior Investigator at the Public Health Institute and Co-principal of the center community benefit insight

A special thank you to the panel of subject matter experts who volunteered their time and expertise to review the submissions and selected those featured in this document. These individuals are:

- John Auerbach, President and CEO, Trust for America's Health
- Dr. Maureen Byrnes, Lead Research Scientist, Milken Institute School of Public Health, George Washington University
- Dr. Karen De Salvo, Professor at Dell School of Medicine, University of Texas
- Dr. Gil Liu, Medical Director of Kentucky Medicaid Services
- Dr. Jose Montero, Director of Center for State, Tribal, Local and Territorial Support Centers for Disease Control and Prevention
- Mylynn Tufte, State Health Officer, North Dakota

A note about the contents of this product: Although the call for abstracts was disseminated broadly and the criteria for selection were carefully delineated, this project is not comprehensive or systematic. Rather, the stories featured here are illustrative even though they are not representative of all the efforts that have transpired or are underway across the nation.

The submissions featured here do not offer a "formula" to pursuing and achieving a fruitful CHNA collaboration. Instead, a set of shared qualities were identified among and across collaborations that foment their success: **trust, commitment, creativity, transparency, neutrality and flexibility.** The requirements and structures articulated in the ACA in terms of CHNA related activities provided the platform upon which these collaborations were built. Momentum, however, was maintained through shared leadership and collegiality among entities. The ever-present challenges of limited time and resources were faced with creativity and flexibility, while the prioritization of community health needs was managed with care. The partners that constitute these state, regional and local collaborations leveraged their individual assets and expertise to build a common agenda toward community health and wellbeing. As the third cycle of the CHNA nears, we encourage our colleagues to pay particular attention to capturing and sharing evaluation efforts to inform this important work in the future.

Terry Allan, MPH
Health Commissioner - Cuyahoga County Board of Health

David Lakey, MD
Vice Chancellor for Health Affairs and Chief Medical Officer - The University of Texas System

EXEMPLARS OF COMMUNITY HEALTH NEEDS ASSESSMENT COLLABORATION

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BEFORE YOU BEGIN READING…

Call for Abstracts Process

The Action Collaborative on Bridging Public Health, Health Care and Community opened a call for abstracts on June 2018 that lasted 8 weeks. There were ultimately 37 completed submissions that were reviewed by the subject matter experts (SMEs). The SMEs used a set of criteria based on the stages of joint action from the National Association of City County Health Officials previously applied to the assessment of CHNA related collaboration (see Beatty et al., 2015). The authors of the selected abstract submissions were invited to further detail their accounts.

Submission Components

The authors of the submissions featured in this document were asked to describe the **structure** of their collaboration, which addressed whether the **arrangement** was formal or informal, how it was **organized**, who their **partners** were, and how **resource allocation** (time, staff, and money) was managed. In terms of, **data, measurement and evaluation,** individuals were asked to describe **data collection** methods, if and how common **objectives, metrics, and measurements** were developed, and what, if any, **evaluation** efforts were performed. They were also asked to share **challenges**, **solutions**, and the **elements of a successful collaboration**. Finally they were asked to articulate what the partners constituting the collaboration were able to achieve together that would not have been possible otherwise, i.e., **the value of collaboration.**

Each of the submissions that follow are structured in accordance to the **subheadings** delineated above.

A Thank you from the authors of the submissions

Those who submitted the accounts in this document would like to thank their colleagues who have worked in their respective CHNA- related collaborations and who contributed to the submissions.

HEALTH ENC - NORTH CAROLINA

Submitted by: William C. Broughton, MA, MPH, CPH Program Manager, Health ENC, & Foundation for Health Leadership & Innovation

Structure

Arrangement

Initiated in 2015 by the Office of Health Access in the Brody School of Medicine at East Carolina University, Health ENC grew out of conversations with health care leaders about improving the Community Health Needs Assessment (CHNA) process in eastern North Carolina. Today, Health ENC coordinates a regional CHNA in 33 counties of eastern North Carolina, and its Program Manager works to build coalitions and partnerships that will address health issues identified through the regional CHNA process. Health ENC is now a program of the Foundation for Health Leadership & Innovation (FHLI), a non-profit organization focused on improving health in North Carolina. FHLI helps Health ENC in building its network and enhancing its overall impact.

As part of the *Affordable Care Act*, not-for-profit hospitals are required to conduct CHNAs every 3 years. Similarly, local health departments in North Carolina are required by the Division of Public Health in the NC Department of Health and Human Services to conduct periodic community health assessments as well. Local health departments have been required to submit their community health needs assessments once every 4 years. The particular year CHNA submissions are made by hospitals within a 3-year cycle or by local health departments within a 4-year cycle is not uniform across the state or region. Additionally, although local health departments and hospitals have guidance from their respective oversight authorities on how to conduct and report the results of their CHNAs, that guidance allows for wide variations in the execution of these reports. The methodologies, specific data gathered, interpretation of the data, and general approach and scope of one CHNA may have little resemblance to a CHNA in another jurisdiction or conducted by another organization.

For these reasons, health care leaders across eastern North Carolina have partnered to standardize the CHNA process for health departments and hospitals in the region. This effort will also synchronize all participant organizations onto the same assessment cycle. Combining efforts into a regional CHNA, is expected to ultimately lead to: 1) an improvement in the quality and utility of population health data, 2) the ability to compare information and interventions across geographic boundaries, and 3) reduce the costs for everyone involved, while maintaining local control and decision making with regard to the selection of health priorities and interventions chosen to address those priorities. Simultaneously, regional collaboration will create opportunities for new and better ways to collaborate with one another.

Organization

Prior to the start of CNHA data collection and the selection of a contracted vendor in early 2018, Health ENC was an informal organization of stakeholders meeting to discuss how to regionalize the CHNA process in eastern NC. While there were workgroups and a Steering Committee created to guide the process, there was no formal membership or commitments structure. As interest developed around formalizing collaboration to take action on specific goals, Health ENC applied for and received grant funds from The Duke Endowment under the administrative sponsorship of FHLI. FHLI issued the request for proposals to solicit bids and contracted with the project vendor, Conduent HCI (Healthy Communities Institute).

To solidify the exact number of organizations taking part in the regional CHNA, individual memorandums of understanding (MOUs) were signed between FHLI and participating counties. MOUs committed the county to the regional CHNA for the 2019 cycle and detailed participation costs, outlined expected deliverables from Conduent HCI, and listed responsibilities for counties. The health department and hospital in each county, or the hospital financially supporting the county, cosigned the same MOUs.

Partners

Partner Organizations

- Foundation for Health Leadership & Innovation
- Brody School of Medicine at East Carolina University
- The Duke Endowment

Hospitals and Health Systems

- Cape Fear Valley Health
- Carteret Health Care
- Halifax Regional Medical Center
- Johnston Health
- UNC Lenoir Health Care
- Nash Health Care System
- Onslow Memorial Hospital
- The Outer Banks Hospital
- Pender Memorial Hospital
- Sampson Regional Medical Center
- Sentara Albemarle Medical Center
- Vidant Beaufort Hospital
- Vidant Bertie Hospital
- Vidant Chowan Hospital
- Vidant Duplin Hospital
- Vidant Edgecombe Hospital
- Vidant Medical Center
- Vidant Roanoke-Chowan Hospital
- Wayne UNC Health Care
- Wilson Medical Center

Health Departments and Districts

- Albemarle Regional Health Services
- Beaufort County Health Department
- Bladen County Health Department
- Carteret County Health Department
- Cumberland County Health Department
- Dare County Department of Health and Human Services
- Duplin County Health Department
- Edgecombe County Health Department
- Franklin County Health Department
- Greene County Department of Public Health
- Halifax County Public Health System
- Hoke County Health Department
- Hyde County Health Department
- Johnston County Public Health Department
- Lenoir County Health Department
- Martin-Tyrrell-Washington District Health Department
- Nash County Health Department
- Onslow County Health Department
- Pamlico County Health Department
- Pitt County Health Department
- Sampson County Health Department
- Wayne County Health Department
- Wilson County Health Department

Resource Allocation

In May 2017, Health ENC received funding from The Duke Endowment to synchronize counties onto the Health ENC CHNA cycle (data collection in 2018, submission in 2019). As MOUs were being drafted, counties were classified as either “off-cycle” or “on-cycle” to determine which partners would receive grant funds.

"Off-cycle" health departments and hospitals were classified as those entities that will have to conduct a CHNA in advance of their normally scheduled CHNA cycle. These "off-cycle" counties have their out-of-pocket costs covered by grant funds to assist them in participating in the regional CHNA. In addition, grant funds are being made available to help cover costs incurred to conduct focus groups and distribute the community survey in each county. "On-cycle" counties are those that aligned with the regional CHNA cycle. These counties are expected to cover their own participation costs because they would have budgeted for a CHNA regardless of the regional effort.

Moving forward, the Health ENC Steering Committee is looking to establish a membership structure for participating counties to assist with program sustainability and cover future costs.

Leadership

While FHLI is the administrative home for Health ENC and provides general oversight, support, and resources, the program also has a Steering Committee that advises the work of the program and is made up of hospital and health department representatives and other health care stakeholders from eastern North Carolina. The Health ENC Program Manager, a full-time employee of FHLI, is tasked with handling the day-to-day affairs of the project. These tasks include coordinating work with Conduent Healthy Communities Institute (HCI), acting as the point of contact for participating hospitals and health departments, and ensuring success of the regional CHNA.

Data, Measurement, and Evaluation

Data Collection

Health ENC collaborates with Conduent HCI to assist with data collection and analysis as well as writing 33 county-level reports using a standard template. Conduent HCI will also be authoring a regional-level report examining health trends and strategic opportunities in eastern North Carolina. Lastly, Conduent HCI has created a web-based platform for Health ENC (www.healthenc.org) that will be an interactive source for all CHNA data collected and for reports, as well as housing other population health resources.

While Conduent HCI has helped with data analysis and writing of reports, participating hospitals and health departments still played a large part in data collection. Counties were responsible for distributing the standardized survey in their communities as well as organizing and facilitating focus groups. Primary and secondary data collection was completed in August 2018, and CHNA reports will be finalized in 2019.

Common Objectives, Metrics, and Measurement

After health departments and hospitals receive their CHNA reports from Conduent HCI in November 2018, they will present the findings to their communities and stakeholders in county-specific prioritization sessions, where they will select the health issues they will be focusing on for the next 3 years. Based on these health priorities and the results of the CHNA, Health ENC will act as the coordinating body to identify areas for regional collaboration. Health ENC’s goal will be to convene partners and seek funding for interventions addressing the health priorities and other health issues identified in the CHNA process.

In addition to authoring 33 county CHNA reports, Conduent HCI is also authoring a regional report. This regional analysis of the primary and secondary data will look at pervasive health issues and needs across eastern North Carolina, and identify strategic

opportunities to improve population health through collaboration. The findings from this report, expected to be completed in early 2019, will provide direction for Health ENC to set regional health priorities.

Evaluation

To date there has been limited evaluation of the process and procedure for Health ENC because the program is still conducting its first data collection cycle. Moving forward, Health ENC plans to partner with an independent evaluator to verify HCI Conduent's data interpretations for primary data collection and analysis. In addition, Health ENC would like to evaluate and verify that the 33 county-level reports satisfied all requirements for the NC Department of Health and Human Services and the Internal Revenue Service.

Collaboration

Challenges

One of the biggest challenges in implementing a regional CHNA in eastern North Carolina has been convincing health departments and hospitals of the potential benefits of partnering in a regional collaboration. During initial conversations with counties regarding who would be willing to participate in a regional collaboration, some organizations expressed the concern about changing their current process and losing their autonomy in collecting primary data and writing the CHNA reports.

To address concerns pertaining to autonomy, Conduent HCI allowed counties to include up to three additional county-specific questions to the community health survey. Interestingly, after reviewing the standardized survey instrument, no counties identified a need to add extra questions. Counties also have the ability to edit and expand the reports they receive from Conduent HCI.

Solutions

Communication was key to overcoming hospitals' and health departments' concerns about regional collaboration, particularly the concerns around the loss of autonomy and potential increased costs of a new initiative. Health ENC listened to these concerns and provided the stakeholders with as much information as was available, then let the stakeholders make informed decisions about their participation in the regional CHNA.

Elements of Success

Key to Health ENC's success was ensuring that, in each county, the health departments had a hospital partner. For the majority of the 33 counties, the local health department in the county was able to partner with the hospital in the respective county. However, when the MOUs were being signed, there were seven health departments that wanted to participate in the regional CHNA but did not have a hospital in their county. For six of these counties, Vidant Health agreed to work with these counties because they are in Vidant's service area. In addition, Vidant Health recognizes the benefit of access to high-quality population health data. Hospital and health department collaboration is critical because it allows the organizations to share responsibilities in conducting their CHNA, share out-of-pocket and in-kind costs associated with the CHNA process, and ultimately create a more comprehensive CHNA report.

Value of Collaboration

Eastern North Carolina is very different economically and demographically from the rest of the state. The region is very rural and health care providers often have limited resources to address population health issues. Collaboration helps health departments and hospital with limited resources to produce high-quality CHNA reports, reduce time and effort staff must spend on the process, and lower costs because of the economy of scale achieved through the partnership. In addition, Health ENC counties will be able to collaborate across county lines to address top regional health issues by applying for grant funds as a collaborative partnership rather than as individual organizations, and with increased collaboration and capacity, Health ENC anticipates a higher success rate of receiving funds, implementing action plans, and achieving outcomes in the region.

KING COUNTY HOSPITALS FOR A HEALTHIER COMMUNITY - WASHINGTON

Submitted by: Joie Hsu, MPH Project/Program Manager II, Public Health - Seattle & King County

Structure

Arrangement

The King County Hospitals for a Healthier Community (KC HHC) and Public Health – Seattle & King County (PHSKC) joined forces in 2012 to identify the greatest needs and assets of the communities they served in order to develop coordinated plans to support the health and well-being of King County residents. During initial KC HHC meetings with hospitals, health systems, and public health, a shared commitment was developed with the goal to collaborate on a joint community health needs assessment (CHNA) in order to avoid duplication of efforts, which, in turn, would help focus available resources on a community's most important health needs. Creating a joint CHNA report would also streamline CHNA activities in the community and therefore alleviate burdening the community with multiple CHNA requests by hospitals/health systems that have similar priorities and/or topic areas. KC HHC and PHSKC have collectively produced two Community Health Needs Assessments – the 2015/2016 CHNA and the 2018/2019 CHNA.

Organization

This collaboration has a formal structure – each hospital, health system, and public health agency created and signed a memorandum of understanding (MOU) as well as a letter of commitment. In addition, a formal charter, created in 2013 and last updated in 2015, outlines KC HHC's approach "to institutionalize a collaborative approach to conduct a comprehensive Community Health Needs Assessment for King County and to identify opportunities for the development and implementation of collective, data-driven strategies."

Partners

- Public Health – Seattle & King County
- Evergreen Health
- CHI Franciscan Health
- Kaiser Permanente
- MultiCare Health System
- Navos
- Overlake Medical Center
- Seattle Cancer Care Alliance
- Seattle Children's
- Swedish Medical Center
- University of Washington Medicine
- Virginia Mason

Resource Allocation

The hospitals/health systems and public health entered into an MOU and letter of commitment in order to allocate pooled funds for the CHNA. These pooled resources from the 11 hospitals and health systems have supported the production of the joint CHNA report as well as CHNA-related activities. Furthermore, PHSKC also donates in-kind hours to support the production of the CHNA report. For the 2018/2019 CHNA report, over 8 epidemiologists and 3 social research scientists as well as administrative staff from PHSKC worked on analyzing data and writing narrative for this report. In addition, representatives from each hospital/health system attend quarterly KC HHC meetings, which are facilitated by PHSKC and hosted by the Washington State Hospital

Association. These quarterly meetings provide a space for shared learning, coordinating efforts, and streamlining resource allocations to support this work.

Leadership

As outlined in the charter, specific expectations and roles are outlined for hospitals/health systems in the King County Hospitals for a Healthier Community (KC HHC collaborative as well as for Public Health – Seattle & King County related to CHNA-related activities. Members of the collaborative have the delegated authority from their organization to make final decisions regarding the process, policies, and financial commitments of their participating organization. Decision-making requirements for the group were outlined as quorum and voting procedures, which were reviewed and agreed upon by the collaborative. At least 80% of members need to cast an affirmative vote in order for a vote to pass on the CHNA budget, scope of work, time line, and major deliverables. If the 80% threshold is not met, there is a process to solicit additional votes as needed in order to make decisions.

CHNA Activity Example

As part of the "triple aim" of health care, members of the King County Hospitals for a Healthier Community are collaboratively addressing challenges related to diabetes, obesity, and access to care. Through collective agreement, KC HHC hospitals and health systems partnered to focus on sugary drink consumption and diabetes prevention as a common priority. During subsequent planning meetings, members reviewed data, developed talking points, discussed how to align individual efforts with collective action, and determined how to engage hospital leadership staff. Through these efforts, all hospital and health systems in the KC HHC adopted a Healthy Food in Health Care Pledge to increase access to healthy food choices within their facilities. Many have also adopted strategies to improve access to fruits and vegetables through Fresh Bucks, on-site farmers' markets, grocery store vouchers for produce, and free or low-cost food bags.

To address access to care, during the first open enrollment period under the new Affordable Care Act each KC HHC member promoted enrollment in communities where residents were likely to be eligible for health insurance. Planning activities leading up to this coordinated effort included focusing on lessons learned from previous outreach and enrollment efforts, reviewing data with PHSKC in order to effectively focus outreach efforts, and engaging and expanding the use of hospital outreach workers.

Data, Measurement, and Evaluation

Data Collection

The data presented in the Community Health Needs Assessment is collected through various surveys and datasets that Public Health – Seattle & King County has access to analyze. The datasets include data from the Behavioral Risk Factor Surveillance Survey, the Healthy Youth Survey, the American Community Survey, death certificates, birth certificates, hospitalizations, Office of Superintendent of Public Instruction, Washington State Cancer Registry, immunization data, and various population data from the Office of Financial Management, among other data sources. The indicators that are included in the CHNA report, along with 110 additional indicators, are also included on PHSKC's Community Health Indicators website (www.kingcounty.gov/chi), which enables KC HHC partners to explore and review more in-depth analysis through interactive data visualizations.

Common Objectives, Metrics, and Measurement

The KC HHC charter as well as expectations outlined in the MOU and letter of agreement have been helpful accountability metrics in order to guide the work and ensure that all hospitals, health systems, and public health agencies understand and adhere to agreed-upon deliverables. Furthermore, PHSKC serves as the facilitator for KC HHC and through this role PHSKC encourages the hospitals/health systems to create recommendations, share best practices for Community Benefit programs, and utilize quarterly meetings to discuss opportunities and align efforts to reduce duplicate work. By serving as a neutral facilitator, PHSKC also works closely with the hospitals/health systems to determine which indicators will have detailed interpretation and analysis in the CHNA report. Through the CHNA indicator selection process, hospitals and health systems are able to align priorities, objectives, and

measures. Throughout indicator selection meetings, members discuss and vote on which health areas and/or topics are most important for all hospitals/health systems to actively track and develop common strategies to address.

For the 2018/2019 CHNA, KC HHC members had a shared objective to focus on lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations through a special LGBTQ Community Spotlight report. By aligning common goals, KC HHC members and PHSKC staff were able to allocate resources in order to gather more qualitative data on the specific health care barriers and opportunities that King County LGBTQ youth and young adults experience. To accomplish this, PHSKC conducted listening sessions with youth and young adults as well as interviewed key informants throughout the county. These qualitative findings are supplemented by data sources that were analyzed by sexual orientation to produce a comprehensive 2018/2019 CHNA LGBTQ Community Spotlight.

Evaluation

As outlined in the KC HHC charter, the primary purpose of the KC HHC collaborative is to share resources and best practices related to a joint CHNA. Because the primary purpose of KC HHC is to create a shared CHNA, there have not been any formal evaluations conducted through KC HHC. Instead, each hospital and health system is individually engaged in separate evaluations within each institution.

Collaboration

Challenges

Although there are strong successes attributed to the King County Hospitals for a Healthier Community, challenges persist, especially when aligning the vision and priorities of diverse organizations and stakeholders toward a common goal. Hospitals and health systems in King County vary in their size and capacity, populations served, shared priorities, as well as implementation strategies. KC HHC's common desire to collaborate on shared priorities across the county through a shared CHNA encourages an atmosphere where hospitals and health systems can focus on opportunities to coordinate strategies in order to improve the health of King County residents.

Solutions

All hospitals/health systems represented in KC HHC discuss and reach consensus on a core set of topic areas that are covered in the CHNA. Through this consensus process, each organization aligns resources and priorities especially for the purpose of this joint CHNA report. Through this approach, hospitals can gather additional information that is specific to their service area by using the baseline data on community health indicators in the CHNA report to describe community needs and highlight disparities, which can then inform strategies that target inequities within each hospital/health system's service area.

Elements of Success

There is a strong commitment from the 11 hospitals/health systems represented in KC HHC to work together to produce a joint CHNA report, share opportunities for coordination, and identify best practices for administering Community Benefit programs. These underlying commitments help create a shared understanding and collective value for this work and are key drivers to the group's success. The KC HHC collaborative allows hospitals/health systems to come together to collaborate—not compete—and find opportunities to leverage resources as a whole to eliminate the burden that 11 separate assessments would place on a community.

Value of Collaboration

This collaborative has been instrumental in developing trust and new relationships across King County hospitals and health systems, which in turn has created opportunities for hospitals to coordinate and work more closely together. By pooling resources to create a cost-effective Community Health Needs Assessment rather than working disjointedly through individual CHNA

consultants, each KC HHC member demonstrates respect and mindfulness by minimizing redundant questions and repetitive data collection in communities. Additionally, KC HHC has also been of great value because it has resulted in the formation of a hospital "table" that serves as the connector to broader countywide health and social service transformation efforts such as Healthier Washington and Washington's Medicaid Waiver project.

One example of a project that was a result of KC HHC is the LGBTQ Community Spotlight that will be released as part of the 2018/2019 CHNA report. It features groundbreaking analyses, stories, and interviews highlighting the health care challenges and opportunities that King County LGBTQ youth and young adults experience. The LGBTQ Community Spotlight examines health inequities from a series of listening sessions with LGBTQ youth and young adults and from key informant interviews with advocates who work with LGBTQ youth. To complement these qualitative findings, relevant survey data from the Behavioral Risk Factor Surveillance System, Healthy Youth Survey, and *Count Us In* Survey of King County's sheltered and unsheltered homeless population are analyzed by sexual orientation and provided in the LGBTQ Community Spotlight as well. These results can be used to raise awareness among health systems, advocates, parents, teachers, health care providers, and other trusted adults whose support is important to LGBTQ populations.

THE HEALTH COLLABORATIVE - TEXAS

Submitted by: Caroline D. Bergeron, DrPH, MSc, CHES, Director of Research and Evaluation, The Health Collaborative

Structure

Arrangement

Community Health Needs Assessment (CHNA) collaborations are unique in Bexar County. More than 20 years ago, in 1997, the four main health systems in Bexar County put aside their competitive practices to conduct one collaborative CHNA. Their focus was on decreasing duplication of services and developing a stronger assessment together that would meet their shared vision and their individual organizational needs. Three years later, the Health Collaborative was incorporated as a 501(c) 3 non-profit organization to continue this work of collaboration. Today, the Health Collaborative is composed of an 18-member board of directors representing different organizations and sectors that govern the organization. Its mission is to improve the health status of the community through collaborative means, and one of its main services is to offer the community a thorough CHNA every 3 years. A committee of the board of directors, the Data Committee, is responsible for the CHNA. This committee expands to a Steering Committee one year prior to the release of the CHNA to obtain more expertise input throughout the process. The Health Collaborative also partners with its trusted data expert, Community Information Now (CI: NOW). CI: NOW is an Urban Institute National Neighborhood Indicator Partner.

Organization

As its neutral convener, the Health Collaborative invites members of several organizations to serve on the larger Steering Committee for the CHNA process. All members are invited formally by email and attend monthly meetings on the second Thursday of the month. Steering Committee members take their responsibility very seriously as they each contribute to improving our understanding of the health status and health needs of the community. The Data Committee Chair leads the Steering Committee throughout all stages of the CHNA process for one year before CHNA submission: design, framing, prioritization, data collection, data analysis, and reporting. Staff at the Health Collaborative provide support in formalizing the process, organizing the meetings, and providing other assistance, as needed. A strategic partnership is formalized between the Health Collaborative and CI: Now. As the CHNA data expert, CI: NOW helps to prioritize the indicators to be examined, seeks quantitative data needed for each indicator (e.g., from the Centers for Disease Control and Prevention, the U.S. Census Bureau, and local hospital data accessible through Healthcare Access San Antonio), and analyzes the requested data for each indicator (e.g., poverty level by race/ethnicity by Census tract). The Health Collaborative staff collaborates with the UTHealth School Of Public Health to lead the qualitative data collection component of the CHNA, which helps to triangulate the quantitative data with the community’s voice. The Health Collaborative also contributes data to the CHNA process through its Pathways Community HUB program addressing the social determinants of health of at-risk populations. CI: NOW compiles the CHNA results, and maps and drafts the final report. The Health Collaborative Board of Directors oversees the entire process and provides final approval of the CHNA report. The final step involves the Health Collaborative rolling out the CHNA report to the community through a large community breakfast with presentation and physical copies of the report, media coverage, and the publication of the report on its website. "For the 2019 CHNA process, The Health Collaborative will also contribute data from its Pathways Community HUB program addressing the social determinants of health of at-risk populations."

Partners

The data committee of the board and the Community Health Improvement Plan steering committee are composed of the following partners:

- CHRISTUS Santa Rosa Health System
- Community Information Now
- Community members
- Health Access San Antonio
- Methodist Health System
- Methodist Healthcare Ministries of South Texas Inc.
- Our Lady of the Lake University
- SA2020
- San Antonio Metropolitan Health District
- Southwest Texas Crisis Collaborative
- University Health System
- University of the Incarnate Word School of Osteopathic Medicine
- UTHealth San Antonio
- UTHealth School of Public Health San Antonio
- The Health Collaborative

Resource Allocation

The Health Collaborative applies for grant funding for the CHNA through local and county governments, health system partners, and foundations. It also requests sponsorships from community partners. There is no dedicated funding stream to support the CHNA; it relies on grants and fundraising. The Health Collaborative is responsible for the financial management of CHNA funds. The Health Collaborative also dedicates three full-time staff along with student interns to the development of the CHNA, including data collection and analysis, participation in the data committee meetings, report writing, and support for the release of the report. Members of the Steering Committee all provide in-kind resources to the CHNA, including their time and effort.

Leadership

The Health Collaborative is governed by a board of directors composed of 18 board members from various sectors in the community, including health systems, city and county government, academia, non-profit organizations, health plans, businesses, and representatives of the community-at-large. A Board Chair, a Vice Chair, and a Secretary/Treasurer form the Executive Committee of the board. The Executive Director of the Health Collaborative reports directly to the Board Chair.

Data, Measurement, and Evaluation

Data Collection

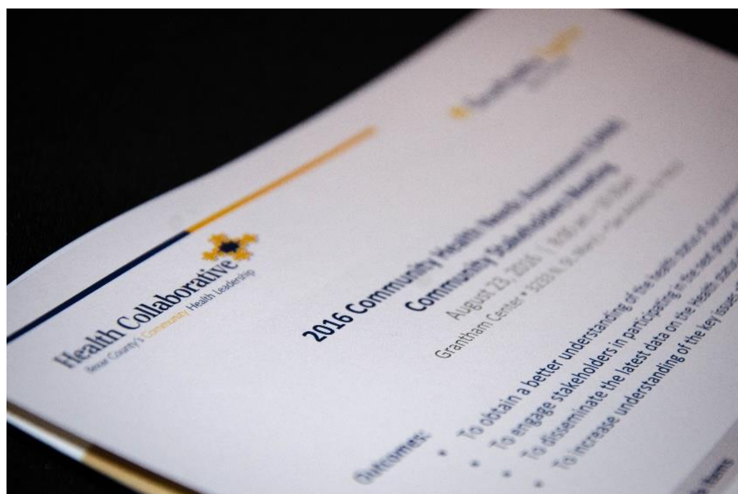
The Board approved CI: NOW as its official research partner for the CHNA. Considering that the population-based CHNA is built on local research and aggregate data, and that The Health Collaborative recognizes the need for local research capacity to support the periodic CHNAs, The Health Collaborative developed a data-sharing agreement with CI: NOW to receive the necessary aggregate data.

Common Objectives, Metrics, and Measurement

The CHNA is a collaborative effort. All decisions, including objectives, metrics, measures, and evaluation strategies, are decided by the group and informed through community engagement approaches and discussions with the data partner. Previous CHNA reports may be found online at http://healthcollaborative.net/reports/.

The Steering Committee arrives at the outcomes in a stakeholder-driven fashion. This differentiates the Bexar County CHNA from other counties that might be relying on external extant data sources.

Evaluation



Immediately following the release of the CHNA, The Health Collaborative begins to design the Community Health Improvement Planning (CHIP) process in partnership with the San Antonio Metropolitan Health District. The CHIP is the action plan that is based on the CHNA results. Strategies and actions are developed with an extensive network of community partners. Subsequently, these actions are implemented, monitored, and evaluated in order to positively influence the initial CHNA results, and ultimately move the needle on population health. The evaluation occurs every 3 years to assess any changes in the community's health status and health outcomes.

Collaboration

Challenges

While the design of the CHNA takes place one full year before its release, the main challenge to establishing and carrying out the collaboration is the efficient use of time. This type of real collaboration takes time. With so many different partners and talents, it is important to agree on a unified vision. Some discussions take a long time to determine the best indicators, to identify key data sources, and to make final decisions.

Solutions

We are in constant discussion with the Steering Committee about our effective use of time.

Elements of Success

The social determinants of health model significantly contributes to the success of the CHNA by providing a framework for discussions related to the design of the CHNA.

All partners and agencies involved in the CHNA bring different skills and knowledge, which contribute to our success and strengthen the CHNA report. CI: NOW is responsible for the quantitative data; UTHealth School of Public Health and The Health Collaborative are responsible for the qualitative data." Each Steering Committee member helps to inform the process, ensuring that we meet the needs of the community. The CHNA also meets Internal Revenue Service requirements.

The success of the CHNA over the years has ensured a growing community interest in the community's own health. This in turn has created a community expectation that has built long-term partnerships, encouraging everyone to take a role in the collective work of the CHNA design and implementation. The CHNA has become a source of community pride.

Value of Collaboration

Collaborating with different entities to produce the CHNA allowed us to comprehensively reveal the health status of the community.

THE MAINE SHARED COMMUNITY HEALTH NEEDS ASSESSMENT – MAINE

Submitted by: Jo Morrissey, Program Manager, MaineHealth

Structure

Arrangement

The Maine Shared Community Health Needs Assessment (CHNA) is a collaborative effort between Maine's four largest health systems and the Maine Center for Disease Control and Prevention (Maine CDC, the state's public health agency). The focus of this effort is to ensure hospital systems have a robust and documented process in order meet their *Affordable Care Act* obligations as spelled out in 26 CFR Part 1 and the State of Maine's Public Health Accreditation Board requirements.

Meeting these requirements was not the original intent of the early collaborators. The Maine Shared CHNA began as the OneMaine Health Collaborative in 2007 as a partnership among Northern Light Health (then known as EMHS), MaineGeneral Health, and MaineHealth (MH) in order to work as a group to better understand the health needs of the communities they all serve. In 2010, OneMaine contracted with the University of New England's Center for Community and Public Health in collaboration with the University of Southern Maine and Market Decisions to conduct a statewide CHNA. This assessment was intended to identify priority health issues where better integration of public health and health care can improve access, quality, and cost effectiveness of services to Maine residents. The project was an effort to share information that can lead to improved health status and quality of care available to Maine residents, while building upon and strengthening Maine's existing infrastructure of services and providers.[1]

After conversations with the Statewide Coordinating Council for Public Health, the Maine Center for Disease Control and Prevention joined the Collaborative in 2012. The effort then became known as the Maine Shared Health Needs Assessment and Planning Process (SHNAPP). Central Maine HealthCare joined the group in 2013.

Organization

In June 2014, a Memorandum of Understanding (MOU) formalized a non-binding agreement through December 31, 2019, among the five signatory organizations. Representatives from each signatory organization form the governing body of the Maine Shared CHNA Collaborative, represented by the Steering Committee. As of October 2018, these members include representatives from Northern Light Health, MaineGeneral Health, Central Maine HealthCare, and the Maine CDC. In 2017, the name was changed to the Maine Shared Community Health Needs Assessment or Maine Shared CHNA. It remains the only statewide public–private effort of its kind in the United States.

Partners

- Central Maine HealthCare
- MaineGeneral Health
- Maine Center for Disease Control and Prevention
- MaineHealth
- Northern Light Health

[1] OneMaine Health Collaborative, Statewide Community Health Needs Assessment, 2010, p. 6.

Resource Allocation

The four hospital systems provide financial support through annual contributions. The Maine CDC provides in-kind support through staffing, data analysis, and community engagement. Now, the MaineHealth system serves as the fiscal agent. In this role, MH provides a duty station for the Program Manager and Human Resources support. This is a rotating role played by the partners. Previously MaineGeneral served in this role and oversaw the first staff person to serve in this position.

Leadership

The collaborative drafted a Charter to provide guidance. According to the Charter, the Steering Committee provides leadership for the creation of an efficient, integrated, and sustainable process to conduct triennial CHNAs and subsequent public health improvement plans/hospital implementation strategies. In addition, this group provides stewardship of the resources made available through the contributing partners. According to the Charter, each member organization has an equal vote in decision making in all matters except finance. In financial matters, only the member hospitals vote. In such instances, decisions are made by consensus by convening CEOs from each of the hospitals to come to agreement. All other decisions (within the agreed-on annual budget) are made by consensus, but allow for an issue to be brought back to the group of member CEOs for resolution. In practice, all members of the Steering Committee vote on all matters and strive for consensus.

The group makes decisions regarding governance and deliverables from the Metrics and Community Engagement Committees and strategic directions for Maine Shared CHNA. The Steering Committee also communicates with CEOs and respective leadership from their organizations in fulfillment of the MOU. This group also oversees the work of the Maine Shared CHNA Program Manager.

The Community Engagement Committee is charged with making recommendations for approval by the Steering Committee outlining a consistent and robust community engagement process. This process should outline a method of disseminating data, identifying health priorities, and identifying assets and resources. The Community Engagement Committee is composed of governmental public health experts, health care employees with expertise in community benefit activities, academia, health care member organizations, and philanthropic organizations who share their expertise with the group.

Both the Metrics and Community Engagement Committee are advisory only and are open to anyone who wishes to participate. The Program Manager convenes the Steering, Metrics, and Community Engagement Committees.

Data, Measurement, and Evaluation

Data Collection

According to the Charter, the Metrics Committee is charged with creating: [1] a common set of population/community health indicators and measures (core and extended lists); [2] a preliminary data analysis plan (to identify the scope of work for the Maine CDC and the Maine Shared CHNA vendor); [3] processes for reviewing indicators and measures regularly to stay abreast of research; and [4] recommendations for annual data-related activities and projected costs associated with recommendations. The Metrics Committee is composed of health data authorities or health data consumers who share their expertise with the group.

Common Objectives, Metrics, and Measurement

The Maine Shared CHNA is currently undergoing its third triennial statewide assessment. Each cycle has resulted in a common set of indicators, a structured statewide format for community engagement, and standard county-level data reports. The objectives of the Maine Shared CHNA are to:

1. Collaborate with key stakeholders across the state, including health care, public health, and community-based organizations to complete a statewide CHNA to help inform public health priorities at the local level.

2. Achieve Public Health Department accreditation through the Public Health Accreditation Board and meet hospital Internal Revenue Service and *Affordable Care Act* rules
3. Use the data to develop local Community Health Implementation Plans

The Mission of the Maine Shared CHNA is to:

- Create Shared Community Health Needs Assessment Reports,
- Engage and activate communities, and
- Support data-driven health improvements for the people of Maine

Indicators are analyzed at the state, public health district, and county levels with urban-level reports for Maine's three largest metro areas: Bangor, Lewiston/Auburn, and Portland.

The most recently completed cycle in 2016 resulted in six commonly selected priorities across the state: cancer, chronic disease, obesity and physical activity, nutrition, mental health, and substance (including tobacco) use.

Evaluation

Although there has been broad statewide support for issues concerning these common health priorities, collaboration on implementing strategies and evaluating the results has not been as sophisticated as the process for identifying them. At this time, each health system and the Maine CDC consult with and monitor each other's progress, but do not formally collaborate on a common set of objectives, measures, progress, or evaluation strategies for addressing these issues.

The 2015-2016 SHNAPP effort included a summary evaluation distributed and completed by members of the signatory collaborative. Evaluation results were also compiled from each of the 34 community forums that were held during that cycle. These findings pointed to the need for changes to data reports and a more consistent methodology in our statewide assessment efforts as well as a reconsideration of the use of a statewide snowball survey.

During the fall of 2018, collaborators embarked on their third statewide assessment process. Evaluation of the effort has been designed to capture another round of feedback from both attendees and planning teams to inform the 2021 assessment. This includes capturing numbers of forum attendees through registration and check-in efforts; ensuring quality of engagement and more granular census of who attended through Participant Evaluation Forms; and reporting prioritized health needs and lists of assets collected at events through the Community Outreach Reporting Tool (CORT). Lastly, new in 2018 is the use of Key Informant Interviews intended to be used to ensure inclusion of views from Maine's most vulnerable populations and from those sectors not well represented at local forums and events.

Collaboration

Challenges

Coming to agreement to partner was the first challenge. Each partner had to "give up" a certain amount of autonomy or perhaps had to make a leap of faith to partner with other similar organizations. Other challenges include selling the investment to leadership and adjusting organizational time lines to fit with the other organizations.

From an operational standpoint, even after each entity's leadership made that leap of faith, fostering lasting collaboration in each community across the state is an ongoing effort. This work involves multitudes of community partners in each of Maine's 16 counties, over which the Program Manager has only influence, but no authority. For instance, each health system consists of anywhere from one to 12 members and affiliates, many with their own population health staff. The Maine CDC oversees nine public health district liaisons, some with up to four counties within their jurisdiction. These numbers swell with the active recruitment and engagement of Maine's 14 unaffiliated hospitals, over 100 Federally Qualified Health Centers, and many other non-profit and community partners. Coming together to agree on methodology, timing, data profile and presentation content and

design, speakers, facilitators, sponsors, and even food for community engagement forums are just a few of the many details these groups need to decide together.

Solutions

Many of these challenges were overcome largely through the realization of the benefits from economy of scale, and demonstrated success of previous efforts. What the Maine Shared CHNA is able to accomplish through partnerships and the pooling of resources could not be accomplished—or paid for—alone. Each consecutive cycle yields products that have been improved upon from the previous effort. Having a dedicated staff member to respond to questions and serve as a sounding board has also been helpful.

Elements of Success

A shared mission, vision, and an agreed upon Charter in order to keep the purpose of the initiative top of mind during deliberations are keys to success. The support of each organization's top leadership formalized by a Memorandum of Understanding signed by each partners' leadership and ongoing formal communication with those leaders fosters sustainability. Steering Committee members' commitment has built a collaboration in which partners trust each other and each other's organizations. Another important element is clearly documented meeting summaries that include a description of the decision-making process, partners involved in the decision, and the final decision itself. Lastly, a dedicated staff member is essential to managing day-to-day operations as well as ensuring an open, transparent, engaged, and well-informed group process that adheres to the mission, vision, MOU, and the Charter.

Value of Collaboration

The collaboration allowed participating organizations to achieve something that could not have been accomplished otherwise: the production of a comprehensive set of data available in a user-friendly format and the capturing, compiling, and summarizing of partner conversations in order to create a final CHNA report for each of Maine's 16 counties, the state, and 5 public health districts.

RUTHERFORD COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT – TENNESSEE

Submitted by: Elisa C. Friedman, Director, Community Engagement and Community Health Improvement, Meharry-Vanderbilt Alliance, VUMC

Structure

Arrangement

Two non-profit health care systems in Tennessee, Vanderbilt University Medical Center (VUMC), an academic medical center, and Saint Thomas Health (STH is the leading faith-based health care system, which is part of Ascension), came together in 2016 to conduct the second cycle of their Community Health Needs Assessment (CHNA) together after having conducted the process separately for the first round of CHNAs in 2013. The two health care systems worked with the county health department in Rutherford County, where the CHNA also served as the Rutherford County Health Department (RCHD) Community Health Assessment. Ultimately the priorities identified by the partnership of VUMC, STH, and RCHD became the driver of the health department's and the Rutherford County Wellness Council's Community Health Improvement Plan (CHIP).

The two health systems and RCHD collaborated on all aspects of the CHNA, including stakeholder and community engagement, collection and analysis of primary data (interviews and listening sessions), identification of health and health-related indicators using secondary data, and data analysis and reporting across these various methods. The partnership also held a joint Community Summit to share the findings from the assessment and, based on these, to facilitate a process in which the community identified and prioritized community needs.

Organization

An agreement was developed between the two health systems that outlined how responsibilities would be allocated across the entire CHNA process. The agreement also mapped out the CHNA process itself (process, methods, reporting) and provided a roadmap for all partners on the agreed-upon process for the CHNA.

A team was created for the Rutherford County 2016 CHNA with institutional representatives from the health systems and the health department. For the current cycle of our CHNA, elements of the NACCHO (National Association of County and City Health Officials) Mobilizing for Action through Planning and Partnerships (MAPP) process are being used in Rutherford County. For example, a "Circle of Engagement" of community stakeholders from across the county representing schools, veteran-serving organizations, and safety net providers, among others, is guiding the process. The two health systems and health department are acting as the "Core Group" and planning team.

Partners

- Rutherford County Health Department
- Rutherford County Wellness Council
- Saint Thomas Health/Ascension
- Vanderbilt University Medical Center

Resource Allocation

Each organization has assigned dedicated staff to the CHNA process. Our greatest resource in the collaboration has been the talents of team members that each of the partners have brought to the process, enhanced by a network of collaborators who share their expertise and insights, such as the Rutherford County Wellness Council.

To provide for the project's financing, an agreement was developed between the two health systems that outlined how monetary resources would be shared for costs such as incentives and food for community listening sessions. The partnership has a shared spreadsheet so that costs can be tracked across all the entities and across all the phases of the CHNA.

Leadership

In Rutherford County, the Core Group of the two health systems and health department leadership guides the process and makes recommendations. These recommendations are then vetted by the Circle of Engagement (a broader collaborative of community stakeholders convened around the CHNA process) and by the Rutherford County Wellness Council, the body through which health issues in the community are assessed and prioritized and a CHIP is developed.

Data, Measurement, and Evaluation

Data Collection

In 2016, the CHNA process included community interviews and listening sessions for primary data and a description of health status using secondary data. In addition to the community interviews, the community listening sessions were key in understanding community members' opinions of health needs and assets within the county. These listening sessions were conducted in both English and Spanish. In 2019, the team added to their methods and conducted a countywide survey and a systematic review of existing reports in Rutherford County that examine health issues as well as determinants of health.

Common Objectives, Metrics, and Measurement

VUMC, STH, and the Rutherford County Health Department continue working together on several projects following the 2016 CHNA process. One of the shared objectives for the partnership was the creation of a Community Health Improvement Plan for Rutherford County. The Rutherford County Wellness Council, consisting of representatives from community-based organizations, faith organizations, government, and other sectors, played the lead role in developing the CHIP, while VUMC and STH provided consultation on formatting, content, and measures. The CHIP is organized around the four priority areas identified through the CHNA process: Access to Care/Care Coordination, Mental Health & Substance Abuse, Social Determinants, and Wellness/Disease Prevention.

Evaluation

The Rutherford County Community Health Improvement Plan lays out measurable objectives that have facilitated the partnership's evaluation efforts. In addition, VUMC and STH include detailed plans for evaluation as part of their CHNA processes. Evaluation of subprojects that rose from the CHNA process are also underway. For example, since 2016 the Rutherford County Wellness Council has issued 19 mini-grant awards. The mini-grants are to be used to educate the community about tobacco use, obesity, physical inactivity, and/or substance abuse issues and concerns affecting Rutherford County and to engage the community in public health activities conducive to reducing the risk of developing chronic disease. In order to address the mission of population health improvement, the mini-grant programs encouraged attention to addressing one or more of the four areas identified in the CHNA process, and grantees also had to address how their proposal gave rise to or strengthened community and public health relationships.

Grantees focused on infant mortality, healthy eating, programs building a culture of health, and reducing juvenile drownings by providing economically disadvantaged youth with aquatic safety lessons and water survival training. RCHD engaged outside evaluation expertise from Tennessee State University College of Health Sciences to ensure grantees had measurable goals that

improved health outcomes. The health systems then supported the evaluation process by developing electronic reporting tools and helped develop reports back to the Rutherford County Wellness Council.

Collaboration

Challenges

One of the main challenges to collaboration was aligning the different community assessment processes and procedures each partner had previously used in order to conduct a joint Community Health Needs Assessment process in 2016. More specifically, STH's process in 2013, VUMC's process in 2013, and the assessment process for the health department all had to merge into one model that all owned in 2016.

While the end product is more valuable, joint decision making can be more time consuming, so the partnership considered this in the development of time lines.

Other challenges included differing institutional missions and cultures (e.g., academic medical center, faith-based health care system, and a county public health department), though this challenge was greatly alleviated by leadership. Time was needed on the front-end to inform leadership about the benefit of a collaborative approach. Ultimately, working as a partnership enabled the community to view the health care systems and health department as a united front focused on improving the health of the community, a departure from the frequent perception of health care systems as competitors.

Solutions

Constant communication across all the partners involved in the CHNA effort helped us overcome challenges such as aligning our processes. The "Core Group" of the partnership communicates regularly, the Rutherford County Wellness Council meets monthly, and the Circle of Engagement, a subgroup that was convened to guide the CHNA process for 2019, meets every other month.

Another strategy that was helpful in overcoming challenges was ensuring transparency around sharing the financial burden of the CHNA process. To this end, the entities maintain a shared spreadsheet to manage and track all costs.

Elements of Success

One of the collaboration elements most important to success was the engagement and support for the Director of the Rutherford County Health Department. She brought a shared vision to the table, acted as a gatekeeper, and facilitated access for everything from primary data collection for the CHNAs to securing the buy-in from the Rutherford County Wellness Council.

The second most important factor that facilitated collaboration was the partnership's commitment to a collaborative process at all stages of the assessment. For example, key informant interviewees were selected in partnership with VUMC, STH, and the Rutherford County Health Department, based on their understanding of the broad interests of the community and underserved populations. Listening session locations and decisions about which indicators to use to describe the health status of the community using secondary data were all made collaboratively.

Institutional agreements that outlined the process and roles up front, including plans for cost sharing, were also helpful. Other factors that were important to success included technology platforms that facilitated teamwork. Finally, the health care systems each had leadership support for a joint process.

Value of Collaboration

One of the biggest achievements of the collaboration was having the health systems and the RCHD agree on the prioritized health needs, which facilitates collaboration and coordination of efforts on the ground. Agreeing on the same health needs would not have happened without the partnership of the two health systems with the health department.

Another contribution of the collaborative approach was the ability to collect more robust data than would have been possible had any one entity been working individually. The CHNA process included community interviews, listening sessions, and a

description of health status using secondary data. In addition to the community interviews, the community listening sessions were key in understanding community members' opinions of health needs and assets within the county. These listening sessions were conducted in both English and Spanish and covered topics such as community assets and issues, health and health care issues, priority actions, and non-emergent use of the emergency department. Again, the depth of data collection would not have happened without the collaboration. The collaboration also reduced the burden of data collection on members of the community who can tire of being the subject of interviews and listening sessions.

The collaboration on the CHNA culminated in development of the 2016-2019 Community Health Improvement Plan, which laid out a strategy for improving the health of Rutherford County and provided a new way for organizing community health improvement efforts in Rutherford. Because of the partnership among RCHD, STH, and VUMC, the work to produce the CHNA and to develop a Community Health Improvement Plan is done collaboratively with individuals and organizations representing a multitude of sectors. Our hope is that this collaboration ultimately facilitates improving community health for all in Rutherford County.

UTAH COMMUNITY HEALTH NEEDS ASSESSMENT COLLABORATION - UTAH

Submitted by: Stephanie Croasdell Stokes, MPH, Sr. Data Analyst, Intermountain Healthcare.

Structure

Arrangement

Encouraged by the new regulations set forth by the Affordable Care Act and public health accreditation standards, the Utah Department of Health, local health districts, not-for-profit hospitals, and other stakeholders across the state of Utah have created a collaboration aimed at successfully designing and implementing a needs assessment that meets each organization's objectives. The purpose of this collaboration is to reduce redundancy, better engage community stakeholders, and bring alignment to the needs assessment and implementation planning processes that will ultimately improve the health of our communities.

Organization

The Utah CHNA (Community Health Needs Assessment) Collaboration is structured as a working coalition composed of representatives from all participating agencies. It is directed by a Community Advisory Panel, which has a formal charter that provides guidance regarding the purpose and work of the Collaboration. The Community Advisory Panel is composed of local health officers and leaders in the state of Utah. While this formal charter provides some guidance, the Utah CHNA Collaboration follows an informal process for decision-making and implementation.

Partners

- Bear River Health Department
- Beaver Valley and Milford Hospitals
- Blue Mountain Hospital
- Central Utah Public Health Department
- Davis Behavioral Health
- Davis County Health Department
- Get Healthy Utah
- Health Insight
- Intermountain Healthcare
- Kem C. Gardner Policy Institute
- Salt Lake County Health Department
- San Juan Health Department
- Southeast Health Department
- Southwest Health Department
- Summit County Health Department
- Tooele County Health Department
- TriCounty Health Department
- Uintah Basin Healthcare
- University of Utah Hospitals
- Utah County Health Department
- Utah Department of Health
- Utah Health Information Network
- Utah Hospital Association
- Wasatch County Health Department
- Weber Human Services
- Weber-Morgan Health Department

Resource Allocation

Each agency has devoted a minimum of one staff member to actively participate in the CHNA activities. Funding for data collection and other tasks is currently supported by Intermountain Healthcare and the Utah Department of Health, with additional support from each local community agency as needed.

Leadership

Two analysts, who serve as co-chairs, currently lead the Utah CHNA Collaboration. One is from Intermountain Healthcare and the other from the Utah Department of Health. While the collaboration committee directs and implements the work of CHNA-related activities, additional support and decision making resides with the Community Advisory Panel, which is made up of public health officers and leaders in the state of Utah.

Data, Measurement, and Evaluation

Data Collection

The Utah CHNA Collaboration collects both qualitative and quantitative data. Within each community, key stakeholders are invited to participate in a community input meeting. These participants represent a broad range of interests, including the health and health care needs of the uninsured and low-income. Discussion highlights specific issues in the community, in addition to concrete examples of challenges, perceptions, and strategies for addressing health needs. An online survey is sent to people who could not attend the community input meeting to encourage more representative feedback and engage all who were invited. Quantitative data for over 100 health indicators is collected through the Utah Public Health Indicator Based Information System. This query-based website provides statistical data on the health status of individuals in Utah communities through evidence-based public health surveys.

Common Objectives, Metrics, and Measurement

The common strategies of the Utah CHNA Collaboration include: (1) initiate relationships with important stakeholders; (2) create a community advisory panel and accountability structure complementary to internal leadership, guidance, and oversight; (3) define shared health indicators for data collection and help improve the state query database; (4) prioritize health needs based on data; (5) organize and convene co-hosted community input meetings; and (6) integrate this collaboration of the community health needs assessment into implementation strategies that become state- and system wide goals and hospital-based clinical programs. All six strategies were implemented in 2016. Strategies are currently in planning for 2019.

Evaluation

Using the RE-AIM framework,[2] a robust evaluation of CHNA-related activities occurred after the 2016 assessment. Opportunities for improvement were gathered using a variety of methods, including key stakeholder interviews and a confidential online survey. Because of this evaluation process, the 2019 CHNA will include more community input, an expanded list of health indicators, and improved communication channels throughout the needs assessment and implementation planning.

Collaboration

Challenges

Several logistical challenges made the establishment and execution of the Utah CHNA Collaboration difficult. The primary challenge is the alignment of time lines; hospitals are required to complete a CHNA every 3 years, while health departments are on a 5-year cycle. This creates some difficulty in engaging community stakeholders in input meetings and keeping momentum throughout the entire process. However, a key benefit of the Utah CHNA Collaboration is that within a few years, all organizations will be on the same time line. Another challenge is finding resources to support ongoing assessment and CHNA-related activities. With the financial landscape of health care and public health funding constantly changing, it is difficult to convince agencies to continue to prioritize resources to maintain the Collaboration. Moving the Collaboration beyond assessment to coordinating implementation strategies is yet another challenge that will be critical to the sustainability of its efforts to improve the health of our communities.

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[2] Glasgow, Vogt, and Boles, 1999.

Solutions

The Utah CHNA Collaboration is still working to overcome many of its challenges. The challenge of alignment among all the participating organizations requires time and patience. However, by maintaining full transparency throughout the process and clear communication of its purpose, the Utah CHNA Collaboration hopes to keep every organization engaged. The Collaboration is also looking for opportunities to highlight early successes from our efforts, such as sharing experiences of local hospital and public health efforts being redirected or improving because of the Collaboration.

Elements of Success

Creating a neutral, transparent platform was key to the success of the Utah CHNA Collaboration. This allowed for the gathering of key community health stakeholders who traditionally do not interact with one another. Ultimately, organizations were eager to minimize redundancy in the various needs assessments taking place and to reduce community fatigue. This motivated traditional, and some non-traditional, partners to engage in the work. Community health needs assessments can be resource intensive, and by creating a platform for transparent and meaningful work, the Utah CHNA Collaboration hopes to streamline the data collection process, allowing for more resources to focus on implementation strategies and improving the health of our communities.

Value of Collaboration

The greatest value of the Utah CHNA Collaboration is the alignment among so many organizations that did not interact prior to 2016. By creating a safe, collaborative working platform for these organizations and their leaders, we can facilitate crucial conversations, research, and planning to improve the needs assessment and implementation planning process. This will ultimately help organizations to address complex health and societal issues.

ADVERSE CHILDHOOD EXPERIENCES COALITION - TEXAS

Submitted by: Nancy Correa, MPH, Sr. Community Initiatives Coordinator, Texas Children's Hospital

*Note that this submission features a specific activity that arose from the CHNA

Structure

Arrangement

Texas Children's Hospital facilitates an Adverse Childhood Experiences (ACE) Coalition to mitigate adversities, foster resilience, and improve outcomes for vulnerable children. Community partners, including hospitals, clinics, academics, local non-profits, and health departments, collaborate to conduct needs assessments that address specific child adversities and social drivers of health. The workgroups first conduct a needs assessment and develop recommendations on how to address the specific adversity. The assessment typically includes a literature review, collection of local data, interviews with key stakeholders, and focus groups. Upon completion of the needs assessment, workgroup members identify and implement strategies to mitigate or prevent the adversity and develop recommendations, which may include programs and services, education and training, policy and advocacy, and research and scholarship. The principles of the workgroups are to be collaborative, action oriented, and data driven.

The coalition is composed of workgroups that address specific adversities. Last year, the ACE workgroups focused on intimate partner violence (IPV), postpartum depression (PPD), and food insecurity.

- Intimate partner violence: The IPV workgroup conducted a needs assessment on IPV screening and identified the need for local health care institutions to improve how IPV screening is being conducted. Focus groups with local survivors of IPV revealed that best practices are not being followed such as screening alone, asking specific and direct questions, and showing compassion. Using the experiences of the local survivors collected through focus groups and evidence from the literature, the collaborative developed a protocol to improve IPV screening and recruited four pilot sites. Two of the four sites did not previously screen for IPV, but are now integrating IPV screening protocols into their workflow. Two of the four sites previously screened for IPV, but improved their screening protocols to reflect the literature and the experiences of local survivors. The IPV screening pilots are currently being implemented, and data are being collected to identify the percentage of eligible patients screened and the rates of positive disclosure to determine whether the new methods improved screening and disclosure rates.

- Postpartum depression: The PPD workgroup identified the need to support local efforts of embedding PPD screening into pediatric practices along with the need to expand the availability of services for women, especially those with low incomes, who screen positive for PPD. To address these needs, in partnership with organizations across the state, the workgroup members successfully advocated for the passage of a state bill, HB 2466, that requires Texas Medicaid to reimburse pediatricians for screening for PPD. In addition, the collaboration also developed a research protocol for a randomized controlled trial to determine if a home visitation program is as effective as a referral to a psychiatrist for moms who exhibit mild to moderate signs of PPD. The research study is currently underway and if successful may lead to more treatment options for women with mild to moderate PPD.

- Food insecurity: The food insecurity workgroup found that many local health care organizations have begun to screen for food insecurity, but need more support in developing an appropriate and effective response to address food insecurity. As a result, the workgroup authored the report, *Food Insecurity Screening in Houston and Harris County, A Guide for Healthcare*

Professionals. The report includes practical advice on how to screen and how to respond to a positive screen along with an extensive list of local food programs and resources. The findings from this assessment also led to the submission of several research grants to study the relative effectiveness of different interventions for food insecurity.

In addition to these workgroups, Texas Children's Hospital has received funding to conduct assessments and build collaboratives that address the impact of parental incarceration on children and explore the medical and mental health care needs of children in foster care, the impact of perinatal opioid use, and the community needs as a result of Hurricane Harvey. These needs assessments are currently underway.

Partners

- Aid to Victims of Domestic Abuse
- Baylor College of Medicine
- Children at Risk
- Clinton Health Matters Initiative
- Community Health Choice
- Episcopal Health Foundation
- ESCAPE Family Resource Center
- First3Years
- Harris County Domestic Violence Coordinating Council
- Harris Health System
- Harris County Public Health
- Houston Area Women's Center
- Houston Food Bank
- Houston Health Department
- Legacy Community Health
- March of Dimes
- Memorial Hermann Health System
- Mental Health America of Greater Houston
- Second Serving
- Texas Children's Health Plan
- Texas Children's Hospital
- Texas Children's Pavilion for Women
- Texas Woman's University
- The University of Texas Health Science Center at Houston (UTHealth) School of Public Health
- University of Houston

Organization

The collaboration consists of members and organizations that voluntarily participate. Participants typically meet monthly, and most members contribute to the work of the collaboration. The collaboration does not have a formal memorandum of understanding or inter-agency agreement with the exception of a few grant proposals that have been developed by members of the coalition.

Resource Allocation

Texas Children's Hospital provided funding for one full-time staff member to facilitate and coordinate the collaboration. Other partners also dedicated in-kind staff time to the workgroups, including attending meetings, writing reports, analyzing data, facilitating focus groups, and advocating for policy changes.

Leadership

Most of the work and decisions from the collaboration are agreed upon by the participants of the workgroup. However, the Texas Children's Hospital Section of Public Health and Primary Care approves major decisions and has an established protocol for identifying areas of focus and project selection.

Data, Measurement, and Evaluation

Data Collection

The needs assessments typically include the following components to gather data:

- A review of the literature;
- Interviews with key stakeholders, community members, and national experts;
- Focus groups;
- Surveys of community members and/or stakeholders;
- Analysis of local data from hospitals, health plans, clinics, and community non-profits; and
- Analysis of local data from national data sources and surveys.

Common Objectives, Metrics, and Measurement

The workgroups use a framework to identify gaps in service and knowledge to address community health needs and strategies to address these gaps. In the first year, each workgroup completes the needs assessment, develops recommendations, and produces a report with the findings from the needs assessment. After the first year, the goals and metrics of the workgroups vary depending on the findings and recommendations from the needs assessment. Each year the coalition tracks its activities. Last year the coalition accomplished the following activities:

- Assessments: Completed three needs assessments on the availability of PPD services, IPV screening, and food insecurity screening. Each of these three assessments resulted in the development of concrete strategies and recommendations on how to address the adversity and improve outcomes for children, families, and the community.

- Collaboration: Hosted 33 workgroup meetings with more than 85 participants representing organizations from academia, health care, local non-profits, and local government.

- Education: Hosted a symposium for 125 attendees and presented the work of the coalition to more than 1,000 people at 26 local, state, and national meetings.

- Policy and Advocacy: Authored a policy brief and in partnership with organizations across the state, successfully advocated for the passage of HB2466, which requires Texas Medicaid to reimburse pediatricians for screening for PPD.

- Research: Developed two research protocols with coalition partners that address the need for more services for women with PPD and the effectiveness of food insecurity interventions. The PPD protocol was selected for funding and the research study is currently underway.

- Publications: Published two white papers, submitted two papers to peer-reviewed journals, and published a series of maps that visualize the availability of PPD services.

- Programs and Services: Developed an evidence-based, survivor-informed screening protocol for IPV that is currently being piloted at four sites.

Evaluation

While we do not formally evaluate the collaborative and partnership, we routinely evaluate the workgroup’s initiatives and progress toward identified goals.

Each year the leadership of the Texas Children's Hospital Section of Public Health and Primary Care reviews the goals from the previous year, progress toward stated goals, accomplishments, challenges, participation in the workgroup meetings, and the recommended goals for the upcoming year. The leadership team also reviews the coalition’s advances in services and program delivery, scholarship and knowledge, policy pursuits, and education and training as well as other community needs and initiatives.

This discussion helps to prioritize the work for the upcoming year to ensure the coalition continues to effectively identify and address childhood adversities.

Collaboration

Challenges

Our collaboration has workgroups that are addressing different childhood adversities. The biggest challenge is prioritizing time and effort, as each workgroup would benefit from additional staff time.

Solutions

To maximize the effort of the workgroups, the workgroup members and the leadership of the Section of Public Health and Primary Care periodically review the work and the direction of the workgroup to determine if the collaboration is still adding value. We are also applying for collaborative grants to support the workgroup's recommendations.

Elements of Success

The key principles of the ACE workgroups are to be collaborative, action oriented, and data driven; these principles have provided a strong foundation to address childhood adversities.

- Data driven: The workgroups strive to be data driven to help identify and address strategies to prevent and mitigate childhood adversities. The assessment phase typically includes a literature review, semi-structured interviews, focus groups, and collection of local data, which are used to identify areas of need and strategies to prevent and mitigate child adversities. A data-driven approach has enabled us to focus our time, energy, and capital in areas where the need is great and we are most likely to achieve success.

- Action oriented: While a key component of the workgroups is to gather data, identify needs, and develop strategies to address childhood adversities, the workgroups strive to be action oriented and to move forward with the identified recommendations. The ACE workgroups are supported by a full-time staff person, which enables continuous progress and forward momentum.

- Collaborative: The ACE workgroups actively seek participation from local government, community non-profits, health care, and academia because we believe each of these sectors is critical in identifying and implementing strategies to prevent and mitigate childhood adversities. In addition, a collaborative approach ensures that our work is not duplicative of other work in the community, but instead complements and supports other efforts. In addition to hosting collaborative ACE workgroup meetings, we participate and support other community coalitions and continuously engage our partners.

Value of Collaboration

Improving population health will require collaboration across sectors, and the ACE workgroups provide a space for the different sectors to collaboratively engage. The inclusion of health care, academia, health departments, and community non-profits has been critical to the success of the collaboration as each sector provides unique and valuable resources and perspectives. For example, a successful clinic-based screening protocol for a social driver of health includes screening by health care providers; referrals to community non-profits; and evaluation by academic partners. In the ACE Coalition, academic partners have been able to help with designing research studies when the collaborative identified gaps in knowledge. Our health care partners have been able to pilot projects in their hospitals and clinics, local health departments have broad knowledge on local community issues and partners; and community non-profits offer extensive programs and services to community members and have more flexibility in advocacy efforts than the other sectors. The collaborative nature of the ACE Coalition has enabled us to address childhood adversities across sectors to more effectively support children, families, and the community.

OLMSTED COUNTY PUBLIC HEALTH SERVICES, OLMSTED MEDICAL CENTER, AND MAYO CLINIC - MINNESOTA

Submitted by: Meaghan Sherden, Community Health Integration Specialist, Olmsted County Public Health Services

Structure

Arrangement

Olmsted County Public Health Services (OCPHS), Olmsted Medical Center (OMC), and the Mayo Clinic have a strong, symbiotic relationship and have collaborated with each other, and other community partners, for many years to serve health needs in Olmsted County, Minnesota. In early 2012, these organizations began planning for a joint, triennial health assessment and planning process - first due to state and federal requirements, but ultimately concluding one joint process was the best strategy and asset for the community going forward. Over the past 3 years - Cycle II - the community of Olmsted County has shown an even stronger investment and engagement throughout the process by the development of the Health Assessment and Planning Partnership. Multiple community organizations contribute to the collaborative effort and provide valuable services every day to keep our community healthy.

Organization

Overall, our structure is informal; we have no written agreements about producing one joint Community Health Needs Assessment (CHNA) for Olmsted County. However, we do have a formal agreement via the community health integration (CHI) specialist contract that includes jointly funding the position and sharing the cost of administering the community survey every 3 years. This year we are working on establishing formal relationships with the funding organizations and community partners to make the process more actionable and sustainable.

Partners

- Mayo Clinic
- Olmsted County Public Health Services
- Olmsted Medical Center
- United Way of Olmsted County
- Rochester Area Foundation

Resource Allocation

Resources for CHNA activities were allocated in several different ways. Each entity contributed funds to administer the CHNA community survey, staff to write the CHNA and gather and review data for the assessment. The Rochester Epidemiology Project, which is part of the Mayo Clinic, also provided in-kind resources for conducting analysis to determine true prevalence rates in Olmsted County via electronic health records. Additionally, the dedicated staff of the jointly funded CHI specialist also allowed for dedicated time for community engagement and additional support in publishing the CHNA.

The community health integration specialist contract was formalized through the Coalition of Community Health Integration (CCHI). The CCHI mission statement is “Creating opportunities to coordinate and integrate efficient and effective services across organizations to improve the health and well-being of our community.” CCHI has three areas of focus: population health, coordinated care, and informatics. CCHI membership includes Olmsted County, Mayo Clinic, Olmsted Medical Center, Zumbro Valley Health Center, United Way of Olmsted County, Rochester Area Foundation, Rochester Public Schools, and Health Plans.

At CCHI, a payment model was determined by the organization's size and vested interest in the assessment and planning process. Mayo Clinic and OMC pay a higher percentage than OCPHS because OCPHS absorbs the in-kind costs of management and supplies, including a computer and office space. The other two funders split the difference.

The contract is a legal document that holds each agency accountable. OCPHS is the fiscal host and invoices each partner on a quarterly basis. The contract also dictates the maximum allowable budget. The annual budget is shared annually with each funding organization.

Leadership

The Core Group provides direction and oversight of implementation of the Olmsted County Community Health Assessment and Planning (CHAP) process. This group meets monthly. Members include Olmsted County Public Health Services, Mayo Clinic, Olmsted Medical Center, and United Way of Olmsted County. The purpose statement of the Core Group is "to collaboratively design, implement and continuously improve the community health assessment and planning process to support and foster opportunities to improve the health of Olmsted County's population."

Data, Measurement, and Evaluation

Data Collection

A systematic process of reviewing and identifying local indicators was conducted to populate the framework. This process included seeking input for potential indicators that were either missing from the 2016 CHNA or were emerging indicators in Olmsted County from the following:

- 2013 CHNA prioritization process participants
- CHNA Data Subgroup
- CHNA/CHIP Core Planning Group
- Public Health Services Advisory Board
- Health Assessment and Planning Partnership

The CHNA Data Subgroup then reviewed and researched current and additional indicators to determine the best indicators to describe the current health and needs of Olmsted County residents.

After an 18-month long process of reviewing indicator titles, definition metrics, and data sources, the Data Subgroup finalized the list to include the 35 CHNA indicators. Several indicators required further data development.

Common Objectives, Metrics, and Measurement

The CHNA is part of the CHAP process that also includes the development and implementation of our Community Health Improvement Plan (CHIP). Our CHIP is community-driven by prioritizing the top health issues for the community; this is based on data from the CHNA and captures community perception. Each of our CHIP priorities has strategies, goals, objectives, and work and evaluation plans, all of which were developed and implemented by community workgroups. Our workgroups are in their first 6 months of implementing a variety of policy, systems, and environmental change work to improve the health of Olmsted County.

The CHAP process also facilitates conversations at the community level on using shared metrics. These efforts have resulted in shared metrics across population reports (Rochester/Olmsted County Compass Points), joint grant writing, and an overall reduction in surveys, and have lowered the likelihood that different organizations use different data points.

Evaluation

We value continuous improvement and strive to improve every cycle. Our current evaluation efforts are focused on process. Activities including debriefs, closing the data loop with community members that have participated in our process, and tracking participation.

Collaboration

Challenges

The majority of our challenges come from not having a formal written agreement that clearly articulates roles, responsibilities, and expectations. Therefore, our focus this year is to establish formal agreements to assist with our process and become more actionable and sustainable. While there is a jointly funded position, finding time do the work at an organization level has also proved challenging. Getting as many community voices involved in the process to ensure the CHNA is a true community assessment is an ongoing challenge.

Solutions

We are still working on overcoming our challenges. Over the last year, we have spent dedicated time to have conversations about roles and responsibilities, reviewing our process, and determine what is essential/mandated by the IRS, PHAB, and our State Health Department. Our core group has also spent time to refine our structure before working to secure additional resources. We hope that once clear structures and functions of each group are established this will make drafting the Memorandums of Understanding easier and the workload of each organization will clearly be defined.

Elements of Success

For our collaboration to work, mutual respect, strong commitment, history of collaboration, and acknowledgment of each entity's expertise is key. Our hospital partners recognized that Olmsted Public Health Services had been doing CHNA work for a long time and had an established framework. Public Health recognized that collaborating with hospital partners allowed for additional resources and access to data.

Our structure includes monthly core group and data subgroup meetings and a jointly funded position (Community Health Integration Specialist). This has also been essential to our success. The monthly meetings with our core group ensure that the work continues, each entity is included in decision-making process, and we are proactive about continuous improvement. A dedicated group of community partners participate in the monthly data subgroup meetings to ensure we are not doing the work in a vacuum. The CHI Specialist dedicated position that is jointly funded has assisted with moving the CHNA process forward as well as financially tying the organizations together.

Value of Collaboration

A true value-add of the collaboration is that our CHNA is a true community document. In many communities, they have multiple assessments and multiple priorities; in Olmsted County we have one. Because our CHNA is a community document, this has allowed for better alignment of resources and initiatives. The collaboration has also allowed for more robust data to be included in our CHNA, including electronic medical records data.

COMMUNITY HEALTH NEEDS ASSESSMENT COLLABORATION IN WILLIAMSON COUNTY - TEXAS

Submitted by: Melissa Tung, MPH, Project Manager, Williamson County and Cities Health District

Structure

Arrangement

From 2015 to 2016, the Williamson County and Cities Health District (WCCHD), three non-profit hospital systems, and two community partners in the county collaborated to produce a 2016 a joint Community Health Assessment/Community Health Needs Assessment (CHA/CHNA) that fulfilled the obligations of each organization. The six original partners along with four additional organizations are in the process of collaborating again to develop the 2019 CHA/CHNA.

Organization

For the 2016 CHA/CHNA, community partners collaborated based on an informal verbal agreement. For the 2019 CHA/CHNA, community partners are collaborating based on a formal written agreement. Memorandum of understandings (MOUs) were drafted to outline partner contributions to the assessment.

Partners

- Ascension/Seton Healthcare Family
- Baylor Scott and White Health
- Bluebonnet Trails Community Services
- Eastern Williamson County Collaborative
- Georgetown Health Foundation
- Lone Star Circle of Care
- Opportunities for Williamson and Burnet Counties
- St. David's Foundation (on behalf of St. David's Healthcare)
- WilCo Wellness Alliance (WWA)
- Williamson County and Cities Health District (WCCHD)

Resource Allocation

For the 2016 and the 2019 CHA/CHNA, the major project components included quantitative and qualitative data collection and analysis, both of which involved an outside contractor and regular partnership meetings. Financial support for these was shared amongst the partners. As the lead organization in the assessment process, WCCHD contributed the largest share of resources to the project. One WCCHD staff member worked on the needs assessment process full-time and two WCCHD staff members worked on

the process part-time. WCCHD managed the quantitative and qualitative data acquisition process. Hospitals covered expenses related to qualitative data collection and partnership meetings.

Leadership

For the 2016 CHA/CHNA, WCCHD was the lead organization in the assessment process. WCCHD, St. David's Foundation (on behalf of St. David's Healthcare), Ascension/Seton Healthcare Family, Baylor Scott and White Health, WilCo Wellness Alliance (the county's health and wellness coalition), and Opportunities for Williamson and Burnet Counties met at least monthly, and more frequently toward the end of the project to share decision making. Decisions were made based on consensus of the group. For the 2019 CHA/CHNA, WCCHD formally convened a task force to lead the assessment process. The original six partners that contributed to the 2016 CHA/CHNA and four additional partners--Lone Star Circle of Care (the county's Federally Qualified Health Center), Bluebonnet Trails Community Services (the local mental health authority), Eastern Williamson County Collaborative, and the Georgetown Health Foundation (a local funding agency)—are convening monthly to participate in the assessment process.

Data, Measurement, and Evaluation

Data Collection

The 2016 and the 2019 CHA/CHNA, integrate multiple quantitative and qualitative data collection methods, which provide a diversified and thorough approach to increasing the validity of published results. Baylor Scott and White contracted with an outside vendor to lead stakeholder focus groups and to conduct key informant interviews. WCCHD led and organized community focus groups and incorporated quantitative data into the CHA, while St. David's Foundation and Ascension/Seton Healthcare Family contributed financially to these endeavors. For the 2019 CHA/CHNA, WCCHD conducted a Community Assessment for Public Health Emergency Response and a Community Health Survey in addition to the data collection methods employed in the 2016 CHA/CHNA.

Common Objectives, Metrics, and Measurement

Through collaboration, the 2016 CHA/CHNA identified the top five health priorities for the county. The three hospital systems and the health district developed separate implementation plans that targeted the same five health priorities. In 2016, WCCHD, in collaboration with the WilCo Wellness Alliance (WWA), developed the 2017-2019 Community Health Improvement Plan (CHIP). The CHIP is the county's plan for tackling the top five health priorities. The WWA is composed of community members and organizations from health care, school, government, business, non-profit, and faith-based organizations. Community members from 4 community groups and 9 working groups held more than 30 meetings to draft action plans. Staff from the three hospital systems were an integral part of these meetings. The WWA uses collective impact to reach its objectives and strategies in the CHIP. During the first year of implementation of the 2017-2019 CHIP, 278 out of 625 members from 140 organizations were active participants in the community health improvement process. Eight out of 10 strategies were either achieved or in progress.

Evaluation

Due to limited time and resources, WCCHD did not conduct a formal evaluation of the 2016 CHA/CHNA outcome/process activities; however, WCCHD did debrief the process. In addition, the health district conducted quality improvement activities to improve the needs assessment process. Through continuous quality improvement, WCCHD identified areas of improvement for the 2019 needs assessment process such as formally convening community partners, developing MOUs to outline partner contribution to the assessment, and pursuing greater community input.

Collaboration

Challenges

Challenges such as differing time lines and a competitive environment among hospitals can prevent a joint assessment project from getting off the ground. An additional challenge is developing a quality CHA/CHNA every 3 years without exhausting health district resources and staff capacity, and overburdening the community.

Solutions

The first hurdle for the 2016 CHA/CHNA was a practical one. While the requirements by the Internal Revenue Services (IRS) and Public Health Accreditation Board (PHAB) were very compatible, the time lines were different. Hospitals must complete their CHNA on a 3-year cycle, whereas the PHAB accreditation required a CHA be completed by health departments every 5 years. While not required to perform another CHA until 2018, WCCHD made the decision to move up its needs assessment time line in order to align with that of the hospitals, who were due to complete a needs assessment in 2016. The hospitals also had to make some time line adjustments, as they were operating on different fiscal year cycles, so their deadlines to submit their CHNA to the IRS varied. With some negotiation and flexibility, all parties were able to commit to a common time line. Hospitals in Williamson County did not have a history of working closely together prior to this project. Here, the central role of WCCHD was key to overcoming this challenge. WCCHD was seen by the hospitals as a neutral party that only had the health interests of the community in mind.

Elements of Success

- Effective utilization of available resources: WCCHD used the CDC ACHIEVE Communities grant as a foundation for community collaboration, which served as a springboard to PHAB accreditation and the eventual partnership with local hospitals for a joint community assessment project. Partners took advantage of existing tools and guidance from the National Association of City and County Health Officials (NACCHO) to organize and implement their assessments.

- Strong and neutral leadership: The central role of the local health district—a non-competitor among competitors, with extensive public health content knowledge and expertise, strong community relationships, and a clear vision—was critical from the initial buy-in phase and throughout the assessment process.

- Organizational flexibility: This flexibility took many forms; most notably, partners had to be willing to change their time lines. In the case of the health district, this meant being willing to adopt the 3-year time frame required by the IRS rather than the maximum 5-year time frame allowed by the PHAB. In addition, partner organizations—specifically, the hospitals—had to be open to a new type of relationship with their competitors.

Value of Collaboration

WCCHD would not have been able to develop a quality CHA without the financial and in-kind support from the hospitals. The hospitals would not have had access to key informants and stakeholders in the community. The collaboration resulted in aligned health priorities among community partners and greater buy-in during development and implementation of the CHIP. These efforts demonstrate that working together can lead to a product with higher quality, greater efficiency, and lower community burden—outcomes of great value in collective work toward improving community health.

COLUMBIA GORGE REGIONAL HEALTH ASSESSMENT AND IMPROVEMENT PROCESS - OREGON

Submitted by: Kristen Dillon, Director, Columbia Gorge Coordinated Care Organization

Structure

Arrangement

Our arrangement involved multiple organizations across two states in rural and frontier counties of Oregon and Washington. While one prior effort had included a hospital and health department within a single county, the first region wide Community Health Needs Assessment (CHNA) was spurred by the establishment of a Coordinated Care Organization (CCO) in the region. CCOs are Oregon's model for delivering Medicaid services through regional organizations that manage a majority of physical, mental, dental, and transportation services for local Medicaid members. Every CCO is required to complete a CHNA every 5 years, and the Columbia Gorge CCO does so through the regional Health Council, a 501(c) 3 organization that fulfills the governance and community engagement roles of the CCO. Health Council staff collaborated with the CCO and hospital leaders to convene the participants in the first regional CHNA in 2013 and the second in 2016. Planning for the 2019 CHNA is now in process, and the number of organizations participating has grown with each cycle.

The regional CHNA aspires to meet the regulatory requirements for public health accreditation, mental health agencies, hospitals, community-migrant health centers, and the CCO. The assessment process is set up to meet the most restrictive requirement of any participant, which means, for example, that the process is conducted every 3 years to meet hospital requirements rather than every 5 years to meet the CCO's requirement.

Organization

The collaboration was formal, via a Memorandum of Understanding. The collaboration developed through extensive outreach to leaders in various organizations. Other principles of the collaboration include a commitment to have standard data to track over time, the flexibility to adapt to changing knowledge, and a strong role for community members and health care consumers in structuring data collection questions.

Partners

Community members have been included in all stages of the CHNA. On a most basic level, community members have participated in the process by responding to surveys and through focus groups.

A smaller group of community members have played a significant role in the design and distribution of the Community Health Survey. For example, the Community Advisory Council (CAC), which oversees the CHNA, reviewed the 2013 survey prior to finalizing the 2016 version. Through that review, the CAC members determined that the first survey showed very low responses to questions asking about childhood trauma experiences. Agency and consumer representatives on the CAC articulated that the data did not match their experience in working with clients, where the rate of trauma history appeared to be much higher. The CAC

recommended extensive revisions to the questions related to traumatic experiences, and the second survey yielded responses more in line with service providers' experiences.

In conducting the survey, CAC members, including Medicaid enrollees and social service agency representatives, became a volunteer workforce to field additional surveys to include hard-to-reach populations. For both CHNA cycles, volunteers fielded surveys in person at community events attended by low-income, ethnic minority, older age, and limited English proficiency populations, as well as providing surveys for completion at agencies serving these populations. This allowed for considerably better information than had been collected on these groups in the past, identifying previously unknown geographic pockets of significant need.

Finally, the CAC has led the process to use the results of the CHNA to create the Community Health Improvement Plan. They have been asked to prioritize areas for action, with a weighting process for votes that augments the influence of consumer members in establishing the priorities of the group.

Coordinated Care Organization

- Columbia Gorge Health Council (CGHC, CCO Governance and Community Engagement partner)
- CGHC Community Advisory Council
- CGHC Clinical Advisory Panel
- PacificSource Community Solutions (CCO)

Public Health

- Hood River County Health Department (Oregon)
- Klickitat County Health Department (Washington)
- North Central Public Health District (Oregon - Wasco, Sherman, and Gilliam Counties)
- Skamania County Health Department (Washington)

Health Care

- Klickitat Valley Health (Washington Hospital-Based Health System)
- Mid-Columbia Medical Center (Oregon Hospital-Based Health System)
- Mid-Columbia Center for Living (Oregon Community Mental Health Program)
- One Community Health (Bi-State Community/Migrant Health Center)
- Providence Hood River Memorial Hospital (Oregon Hospital-Based Health System)
- Skyline Hospital (Washington Hospital-Based Health System)

Government and Private Sector

- Four Rivers Early Learning Hub (Oregon)
- United Way of the Columbia Gorge (Bi-State)

Resource Allocation

All participant agencies made an in-kind contribution, for example, fielding surveys and hosting a focus group. Eight organizations provided cash contributions, which largely supported the Community Health Survey, conducted by the Providence Center for Outcomes Research and Education (CORE). The Health Council and Providence Hood River provided significant in-kind contributions of staff time.

Leadership

The PacificSource Columbia Gorge CCO is required to have a Community Advisory Council (CAC) with Medicaid consumers constituting a majority of its members, and state law charges the CAC with overseeing completion of the CHNA. In the Columbia Gorge, the Health Council convenes the CAC, and the CAC, together with Health Council staff and leaders from several participating organizations, organized and led the work.

Data, Measurement, and Evaluation

Data Collection

Financial and organizational resources were pooled for all data collection activities. The Community Health Survey is a standard format developed by CORE that uses mail surveys of local residents as its primary source. Other data were obtained from hand-fielded surveys, organizational surveys, health systems data, and focus groups. Public data (Oregon State Healthy Teen Survey, demographics) were used where available.

Common Objectives, Metrics, and Measurement

Over the two CHNA cycles, process improvement strategies have included collecting standard data while adding questions about emerging concepts. Questions about social needs such as housing security, trauma-informed care, and food security have been incorporated into the CHNA over time. We are repeating this process for the 2019 CHNA by using the CAC to review survey questions and revise as appropriate.

Using the CHNA, the priority action areas are articulated in a Community Health Improvement Plan (CHIP). For 2016, the CHIP was structured using the Robert Wood Johnson Foundation's Culture of Health Action Framework. The CAC prioritized several health drivers and, where necessary, customized the metrics to be used to measure progress. Providence Hood River Memorial Hospital, the Columbia Gorge Health Council, and the United Way of the Columbia Gorge have aligned their allocations with the CHIP.

Evaluation

Significant evaluation has been conducted on the Community Health Survey, which is mailed to thousands of households in the service area and distributed at service agencies and community events. CORE uses the same set of validated questions across multiple Providence Health System service areas in the Western U.S. This has allowed for comparison of survey responses across communities beyond the Columbia Gorge region.

A second evaluation involved the region's process for fielding surveys at agencies and events to reach groups of people who have a history of poor response to mailed surveys. This strategy was initially a source of concern for the researchers because of its potential to distort survey results. In the end, this strategy allowed the survey to reach important target populations and has been adopted across the region by CORE.

Evaluation has also included the organizations who participate and adopt the CHNA to meet their organizational or regulatory needs. Prior to the second and third cycles of the process, each organization submitted the requirements that they needed the CHNA to meet. This year, prior to cycle 3, leaders of the CHNA have also solicited information about how the CHNA has been used by the participating organizations, both externally and internally.

Collaboration

Challenges

Our effort has experienced several challenges, some of which we have surmounted, and others of which remain a work in progress. Challenges successfully addressed after the first CHNA cycle (2013) included: lack of history of collaboration and, in places, history of organizational conflict or collaboration failures; market competition among many of the participating organizations; risk that the collaborative effort would not meet regulatory time lines; and the concern of organizations with regulatory requirements,

that the ultimate product would not meet their specific requirements or speak to the specific needs of their population or geography.

Current challenges we are working to address include: difficulty prioritizing identified needs; tension between limiting survey length and desire to gather more extensive data; tension between leaving survey questions unchanged (to allow comparison over time) and editing questions based on feedback from prior years to make them easier to understand; and lack of quantifiable comparisons between identified needs in order to prioritize intervention plans.

Solutions

The leaders of the effort overcame a history of competition and limited collaboration among organizations through individual contacts with organizational leadership, careful scoping of the work to avoid disclosure of proprietary information, and intentionally setting up a process that was centered in the community, not a single organization.

As an example of this, the organizers of the initial meeting of all the potential collaborators determined that the location should be as close as possible to the center of the geographic region to be served. This meant that the kickoff meeting of the first (and second) CHNA took place at the Corner Pocket Bar in the tiny community of Lyle, Washington. In addition, perhaps more important than any single tactic, the project depended on an optimistic commitment from individual leaders in multiple organizations that a joint effort was possible and worth the effort.

Once the parties had agreed to the effort, skilled project management was crucial to keeping everyone at the table. Documents such as signed agreements that specified what each organization would contribute and a detailed project time line allowed participants to be confident that the project would meet their needs in both quality and timing.

Elements of Success

The collaboration succeeded for several reasons. First, it provided organizations with a process that cost less and created a better product. In addition, conducting a CHNA was a daunting prospect for many of the smaller organizations in the region, so help was welcomed. Initially, there was some safety in the understanding that the process would create a base product that would still allow the flexibility for each organization to add content as needed. Finally, several large organizations were early participants, bringing credibility and resources to the process.

Compared to a process conducted by an individual organization, the shared effort resulted in a better product because it surveyed a larger number of households, incorporated additional data sources, garnered more meaningful consumer input, and generated a document that aligned multiple organizations around shared priorities. For each organization, this was accomplished with lower financial cost and less staff time than performing their own evaluations. Through the multiple cycles of assessment, the focus has also shifted from meeting regulatory requirements to fostering an aligned effort to meaningfully impact health outcomes.

Emerging from the CHNA, the community had a single, accepted set of high-quality data, which created significant efficiency across organizations that had previously needed to each maintain and research their own distinct datasets for activities such as service planning and grant applications. In addition, the survey itself provided a standard set of questions that have served as a template for program evaluations and other surveys.

The quality of the product and process has led to organizations' continuing to participate through multiple cycles.

Value of Collaboration

In addition, the collegiality fostered by the successful, shared work has improved trust and working relationships across organizations for other activities. For example, a community grant writer, funded by Providence, is now available to assist any community organization in securing funds to address CHIP-identified priorities. This program has brought in nearly $10 million in outside grants for collaborative work in the region. Aligning work across organizations has contributed to a wider reach, more thoughtful interventions, and improved outcomes.

THE LOS ANGELES COUNTY COMMUNITY HEALTH ASSESSMENT AND ACTION PARTNERSHIP – THE LA PARTNERSHIP – CALIFORNIA

Submitted by: Paul Simon, MD, MPH, Chief Science Officer, Los Angeles County Department of Public Health

Structure

Arrangement

Prior to the establishment of the LA [Los Angeles] Partnership in October 2015, most hospitals in Los Angeles County worked independently or in localized collaborations on their community health needs assessments (CHNAs), engaged the Department of Public Health (DPH) only sporadically, and did not collaborate or share information regionally.

The LA Partnership started as a conversation between community health staff at non-profit health systems, with subsequent outreach to DPH, the regional hospital association (Hospital Association of Southern California, or HASC) and the California Community Foundation (CCF). Those discussions resulted in the formation of a Steering Committee and, ultimately, invitations to all non-profit hospitals in Los Angeles County to participate.

The LA Partnership is now a collaboration among DPH, HASC, CCF, Long Beach and Pasadena city health departments, and 36 medical centers/hospitals. Its mission is to maximize the collective impact of community benefit activities in Los Angeles County by promoting best practices and alignment in CHNAs and prevention-oriented implementation strategies among hospitals and community partners. The LA Partnership aspires to advance its mission through a collective impact model, consisting of a common agenda, shared measurement, coordinated and mutually reinforcing activities, ongoing communications, and backbone support that engages multiple organizations. Establishment of the LA Partnership represented a major culture change, promoting a higher level of trust and initiating conversations about how hospitals could work more closely together among themselves and with DPH to ultimately have a broader impact by using comparable CHNA data and working jointly on intervention strategies to address shared priority needs.

Organization

The LA Partnership is led by the Steering Committee, charged with coordinating and advancing the collaborative's efforts. In March 2017, the Steering Committee presented a charter to the full LA Partnership membership that outlined the mission, structure, and values; roles of the Steering Committee and workgroups; and guidelines for participation by hospitals. With some modification, the full membership approved the charter in May 2017. The LA Partnership’s efforts are furthered through: (1) monthly Steering Committee meetings, (2) convenings of all LA Partnership hospital members on a biannual basis, and (3) designated workgroups. To date, two workgroups have been established, an Assessment and Measurement workgroup and a Diabetes Prevention workgroup.

Partners

- Adventist Health (Glendale, White Memorial)
- Beverly Hospital
- California Community Foundation
- Cedars-Sinai Medical Center
- Children's Hospital Los Angeles
- Citrus Valley Health Partners
- Dignity Health (St. Mary Medical Center, California Hospital Medical Center, Glendale Memorial Hospital and Health Center, Northridge Hospital Medical Center)
- Good Samaritan Hospital
- Henry Mayo Newhall Hospital
- Hospital Association of Southern California
- Kaiser Permanente (Baldwin Park, Downey, Los Angeles, Panorama City, South Bay, West LA, Woodland Hills)
- Keck Medicine of USC
- Long Beach Department of Health and Human Services
- Los Angeles County Department of Public Health
- Martin Luther King, Jr. Community Hospital
- MemorialCare
- Methodist Hospital
- Pasadena Hospital Association, LTD (Huntington Hospital)
- Pasadena Public Health Department
- PIH Health
- Providence Health & Services (Holy Cross, St. Joseph, Tarzana, Little Company of Mary San Pedro, Little Company of Mary Torrance, St. Johns)
- Torrance Memorial Medical Center
- UCLA Health
- Valley Presbyterian Hospital
- Verity Health Saint Francis Medical Center

Resource Allocation

The LA Partnership is an all-volunteer group of hospital community benefit and community health leaders and representatives from 36 hospitals, 3 local health departments, HASC, and CCF. Meeting expense has been covered by CCF.

Funds to conduct CHNA activities are pooled by hospitals that share the same/similar service areas and are typically allocated to support a shared consultant leading the efforts, and to align and coordinate qualitative data collection from community stakeholders.

There are no funded staff for organizing the collaborative activities. Staff time and meeting expenses are contributed voluntarily by Steering Committee members through the organizations they represent. The California Community Foundation provides backbone-staffing support for the LA Partnership, coordinates Steering Committee calls, facilitates communications with all participating hospitals, and hosts LA Partnership and most workgroup convenings. DPH has allocated staff time in its Office of Health Assessment and Epidemiology to work proactively with hospitals on their CHNAs.

Leadership

The LA Partnership is led by the Steering Committee that consists of senior representatives from DPH, four non-profit hospital health systems (Dignity Health, Kaiser Permanente, Providence Health and Services, and Adventist Health White Memorial), the Hospital Association of Southern California, and the California Community Foundation. The Steering Committee meets monthly and additionally as needed to coordinate the activities of the LA Partnership, including: (1) prioritizing areas/topics of potential alignment by region/geography, (2) convening hospitals to define data needs in support of assessment and planning with DPH and the Long Beach and Pasadena city health departments, (3) sharing community improvement plans and efforts to support coordination, and (4) guiding specific workgroups, as needed. Steering Committee members help to facilitate the workgroups, in conjunction with volunteer representatives from other hospitals.

Data, Measurement, and Evaluation

Data Collection

With input from the hospitals, DPH created a core set of 65 health indicators for which it is providing customized datasets to hospitals for their CHNAs. These indicators include measures of the physical and social environments as well as health behaviors and health outcomes. DPH used geographic information systems to generate maps for hospitals to see their shared community service areas across the county to promote additional collaboration. The LA Partnership's Assessment and Measurement Work Group has created a shared set of primary data collection tools (e.g., interview, focus group and survey topics, questions, and protocols) to achieve greater comparability of CHNA primary data with respect to community engagement and input. These are being implemented for the 2019 CHNA cycle by many LA Partnership members.

Common Objectives, Metrics, and Measurement

To date, LA Partnership has yielded several successes:

- Creation of a core set of 65 health indicators for which data from secondary data sources will be provided by DPH to participating hospitals for their CHNAs. This represents a major advance in DPH’s work with hospitals in several respects. First, it has ensured that hospitals will include a rich array of data on social determinants of health in their CHNAs, a practice that was highly variable prior to the establishment of the LA Partnership. Second, by standardizing the data used in CHNAs across hospitals, we have greatly advanced our ability to compare results across hospital service areas and to promote collaborative efforts among hospitals and with other community partners. To date, DPH has provided data on the core indicators to seven hospitals, and analyses are in progress for an additional six hospitals.

- The introduction of a new tool developed by the Public Health Alliance of Southern California in collaboration with academic and community partners (Healthy Places Index: https://healthyplacesindex.org//) is providing opportunities for hospitals to look at an expanded set of granular data to: (1) identify a common set of underserved communities that can be prioritized by hospitals, and (2) better characterize social and physical environments in these communities. The Steering Committee is reviewing this tool to facilitate a common foundation for understanding underserved communities and the role of social determinants in health outcomes.

- The LA Partnership identified the common health needs that hospitals are addressing and is strengthening the hospitals' understanding of using evidence-based strategies, focusing on up-stream factors. The LA Partnership created the opportunity for DPH to promote the LA County Community Health Improvement Plan and to provide guidance on key goals and strategies to address health needs, which have guided hospitals on evidence and promising practices to inform their Implementation Strategies. Many hospitals have adopted these practices as part of their community health improvement efforts.

Evaluation

The workgroup is in the process of defining what success will look like over the next several years. As firm commitments are established on joint implementation strategies, an evaluation plan will be developed that will include both process and outcome metrics.

Collaboration

Challenges and Solutions

- Los Angeles County’s size and diversity impact collaboration: The requirement and reality that hospitals conduct CHNAs and deliver programs for their local service areas can impose practical limitations on collaboration across Los Angeles County’s 10- plus million residents and over 4,000 square miles. A single county-wide assessment process would not meet all local needs. The LA Partnership has added value in part by helping to design and build common tools and approaches to assessment,

and by providing a shared forum for implementation strategy discussions that are helping to align CHNA processes while not impinging on any one organization's need to assess local needs.

- Differences in the timing and practices of CHNA processes: Given the size and diversity of the county, and the sheer number of hospitals in the LA Partnership, it is not realistic to aim for a single unified process. Local relationships, historically used assessment methods, and different consulting support make for a varied landscape. As with the challenges of a large and diverse population, the LA Partnership's solution to this is to create and make available transferrable, replicable data tools and practices. Thus, each hospital and collaboration of hospitals in Los Angeles County can adopt and integrate these into its CHNA and implementation strategy cycle in ways that make sense locally while still achieving the LA Partnership's larger aim of a more consistent and comparable CHNA process overall.

Elements of Success

- Backbone agency to support ongoing communication, coordination, and convening: CCF's commitment of facilitation expertise, "project management," and the expense of staff and meeting space have enabled this all-volunteer effort to gain momentum and maintain continuity.

- Public health agency engagement: Because hospital CHNAs draw heavily from public health data, and because many of the hospitals' community health intervention strategies include public health-inspired approaches, the consistent and active engagement of the public health agencies has helped with efficient and effective use of resources. Whereas DPH and the other agencies would typically work one-on-one with hospitals, the LA Partnership forum has broadened the reach and benefit of public health analytic support and the inclusion of public health tools, such as the DPH Community Health Improvement Plan and the Healthy Places Index, into CHNAs and implementation strategy development. It has also strengthened public health's understanding of hospitals' assessment needs and their health improvement resources.

- Collaborative relationships among hospitals on community health topics: While hospitals and health systems frequently compete in the realm of clinical services and market share, the LA Partnership has benefitted from and helped to build on an atmosphere of trust and collaboration among multihospital systems and independent hospitals. The LA Partnership has become a regional forum for sharing best practices and discussing new ways to work together on behalf of both local areas and the broader county. This is manifest in work to align CHNA indicators, data sources, and methods, and in planning to identify shared approaches to scaling diabetes prevention.

Value of Collaboration

The Diabetes Prevention Workgroup has raised awareness among hospital representatives of the range of diabetes prevention interventions that are either evidence-based or considered by DPH to be promising practices. The Workgroup has provided a forum for DPH to share its current diabetes prevention efforts and propose opportunities for hospitals to invest their community benefit dollars most strategically to support these efforts. In addition, the Workgroup has served as a forum for hospitals to share with each other their current community benefit activities, priorities, and interests, thereby helping to build a foundation for future collaborative work.

SIOUX FALLS HEALTH DEPARTMENT - SOUTH DAKOTA

Submitted by: Mary Michaels, Public Health Prevention Coordinator, Sioux Falls Health Department

Structure

Arrangement

The Sioux Falls Health Department collaborated with two health systems in Sioux Falls to collect data and produce a single Community Health Needs Assessment (CHNA) report for the the Sioux Falls community, and that report was released in 2016. During the previous CHNA cycle (2013), each entity had produced separate reports about the community.

Organization

The collaboration for the Sioux Falls CHNA utilized an informal structure, with verbal agreements among the primary partners to outline the scope of work and the responsibilities of each partner.

Partners

The primary partners involved in the collaboration were the City of Sioux Falls Health Department, Avera McKennan Hospital & University Health Center, the Avera Heart Hospital, and Sanford Health. In addition, these partners sought input from a number of stakeholders throughout the community, representing such sectors as education, worksites, the faith community, and non-profit organizations.

- Avera McKennan Hospital & University Health Center
- Avera Heart Hospital
- City of Sioux Falls Health Department
- Sanford Health

Resource Allocation

The Sioux Falls CHNA partners met to determine how resources would be allocated for the various data collection and report-writing activities. Each partner agreed to lead a component of the work, which included staff or other resources needed to complete the tasks. The health department staff served in the project management role for the collaboration.

Leadership

A core team of five people, representing the primary partner organizations, guided the CHNA activities. This team then called upon their respective organization's leadership as needed (e.g., public health director and hospital CEOs).

Data, Measurement, and Evaluation

Data Collection

When the partners met to allocate resources for the project, each agreed to lead a component of the data collection. Sanford Health distributed a generalizable survey for residents in the Sioux Falls Metropolitan Statistical Area. The survey asked questions about overall concerns within the community as well as questions related to their individual health conditions and health behaviors. The Avera McKennan team organized a series of focus groups and key informant interviews exploring community strengths, gaps, resources, and recommended actions. Finally, the Sioux Falls Health Department utilized a tool developed by the South Dakota Department of Health called the Good & Healthy SD Assessment to conduct assessment meetings with representatives from other city departments as well as from the non-profit, worksite, education, and health care sectors. The health department also took the lead in collecting information on health indicators from secondary data sources.

Common Objectives, Metrics, and Measurement

While each organization maintained some individual objectives, metrics, and evaluation strategies, the collaborative CHNA work also developed common objectives and measures that the core team continued to monitor. The primary health issues identified were (1) obesity (poor nutrition and lack of physical activity), (2) behavioral health and substance use, and (3) access to care. Within these three priority health areas, the group established collaborative strategies to address together with other community partners. One strategy focused on health interventions within a Sioux Falls neighborhood impacted by a number of social determinants of health. The second strategy involved establishing a community stakeholder group to explore assets and needs related to behavioral health and substance use, and that group continues to meet. The third strategy was to participate in the development of the “Sioux Empire Network of Care,” which seeks to improve access to care issues for Sioux Falls residents.

Evaluation

Following the completion of the CHNA, the partner organizations—the Sioux Falls Health Department, Avera McKennan Hospital and University Health Center, and Sanford Health—held a news conference to present the results to the community. The entities outlined the priority health issues identified through the CHNA as well as the three collaborative strategies that the three partners would focus on during the 2016–2018 period. The health department led the Hayward Thrive neighborhood strategy, and both health systems were instrumental in having staff participate and in providing resources to deliver health interventions within that neighborhood. The health department also formed the behavioral health stakeholders group, of which both health systems are members, and all three partners are represented on the Sioux Empire Network of Care. Over the past 2 years, the partners continued to communicate with each other about these collaborative strategies as well as discussing processes and measures that will be used as they collect data this year (2018) for the next CHNA report to be released in 2019.

Collaboration

Challenges

There were a number of challenges the Sioux Falls partners had to address during the CHNA process, including:

- Identifying the data that should be collected.
- Distributing the workload for the various components of data collection.
- Addressing each organization's time line for report completion to ensure hospitals had time to secure board approvals and to develop implementation plans in order to meet Internal Revenue Service regulations.
- Understanding the "culture" that existed within each partner organization to learn how to work with each other and meet each other's needs.

Solutions

The five core team members of this CHNA process created an environment of respect and trust that allowed them to work through challenges that arose during the process, such as differing opinions or changing time lines. While the competition between the two health systems is often at the forefront of public discussion and media stories, having the City's public health department as a neutral partner enabled the team members to have open and honest discussions. Because the leadership of each organizational partner valued a collaborative approach to the CHNA, additional staff or other resources needed for the project were made available to ensure the project's success.

Elements of Success

This project brought together a government entity and two competing health systems that have unique approaches to how they do business. That factor alone made this effort innovative and unique. By looking at how each organization completed its own CHNA in 2013, however, we were able to identify the strengths and resources each partner brought to the table. Ultimately, that is how we were able to organize the work for our collaborative CHNA.

One of the key "lessons learned" was this: When you have a project that involves a diverse group of partners, including two strong organizations from the same industry, factors such as open communication and trust become essential to the project's success. We are proud of the way our core team of project partners communicated with one another.

While the response to the 2016 CHNA report was overwhelmingly positive, what was perhaps even more valuable to the community was seeing the two health systems and the city come together to complete the assessment. We have enjoyed continued collaboration in the implementation of priority strategies over the past 2 years. In addition, we have nurtured an ongoing relationship with one another that has now brought us to the next CHNA cycle, which we are again embarking on together as partners.

Value of Collaboration

In 2013, each partner organization completed its own CHNA. While each report contained valuable information about the health of our community, the collaborative report released in 2016 was truly a more comprehensive look at the health of our residents and of Sioux Falls. We would not have had such a thorough report without the individual resources each organization brought to the effort.

For example, the Sioux Falls Health Department would not have had the resources to complete a generalizable resident survey or to contract with a consultant to conduct focus groups. However, the health department did have the staff capacity to manage the project, which was a benefit for the hospital partners, whose core group members had a number of other job responsibilities in addition to the CHNA.

Aristotle said, “The whole is greater than the sum of its parts,” and that was certainly true in this collaboration. While each partner organization brings value to our community, that value was multiplied when these individual organizations became connected through the CHNA process.

QUESTIONS?

If you have any questions please contact:

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