



Health Resources in Action
Advancing Public Health and Medical Research



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CHI Processes Evaluation

Evaluating the Promise of Community Health Improvement Processes

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Executive Summary

Contemporary approaches to community health improvement involve partnerships working together to address shared community health, education, housing, and other needs. We evaluated 10 community health improvement processes varying in geography and population to understand the extent of shared community health improvement efforts. Using a variety of methods, we identified these sites from approximately 125 across the nation.

The community health improvement processes we examined are improving alignment of partner efforts and resources within their communities. Alignment is facilitated by developing infrastructures that meet the context, needs, and will of the partners. CHI processes reviewed vary in the extent to which assessment, prioritization, and implementation efforts are shared. Through a variety of structures, these collaboratives create, support, and participate in community engagement efforts. Finally, these collaboratives are demonstrating promise to improve community and population health through implementing strategies that address social determinants of health to reduce health disparities and by implementing policy, systems, and environmental strategies that impact the health of the whole community.

Introduction

The Internal Revenue Service (IRS) Community Health Needs Assessment (CHNA) requirements, especially the implementation strategies for non-profit hospitals, have the potential to refocus healthcare efforts “upstream” to address the social and behavioral determinants of health and achieve population health improvements. The IRS discusses “CHNAs” in the form of community health needs assessments and strategic implementation plans. Through this project, we expanded the framework of CHNAs to include the entirety of the community health improvement process: *assessment, planning, implementation of initiatives, and monitoring and evaluation (hereafter, CHI processes)*.

With support from the Robert Wood Johnson Foundation, Health Resources in Action (HRiA) conducted 10 in-depth case studies of CHI processes that include hospitals to examine the extent to which these processes:

- improve alignment of community health improvement activities,
- foster organizational collaboration and coordination among partners, and
- show promise to improve health outcomes and health equity.

This brief offers key findings from the case studies. Details about the evaluation methodology can be found in the Appendix and the criteria used to select the sites are shown to the right.



Selection Criteria for Case Study Sites:

- Site implements a single, grounded, and **collective process** that integrates hospital, health department, and community priorities, including identifying the root causes and social determinants of health problems within a community
- Process includes full, **broad community engagement**
- **Intended outcomes** (including reduction of inequalities and inequities) are **clearly defined**
- Out of the assessment come clear, focused, **measurable objectives and outcomes**, including outcomes that address health inequities
- Outcomes are realistic and addressed with **specific action plans** designed to eventually improve population health, including reducing inequities
- Plans become **fully integrated into agencies** and become a way of being for the agencies



Sites We Visited

Figure 1 shows the geographic distribution of the 10 case study sites. These sites covered population sizes ranging from 59,000 (Bowse County, VT) to more than 2 million (King County, WA).

As shown in **Table 1**, several site characteristics emerged as important during the case study site visits. Half of the collaboratives have mixed leadership where members of the leadership team are employees of different organizations. Four are led by a hospital or health system. Two of the sites, Healthy Baton Rouge and the Health Collaborative of Bexar County, created 501(c)3 entities to manage the work of their respective collaboratives. Half of the sites had been functioning as a collaborative for more than ten years at the time of the site visit.

Hospitals engaged in these collaboratives are working to advance population health through a variety of efforts. Six sites have academic medical centers as members of the collaborative. Academic medical center partners may have institutes for clinical translational science research or patient-centered outcomes research, both of which require community engagement processes. These community en-

agement processes ensure that, much like a CHI process, research priorities meet community needs. Five sites have members that are in accountable care organizations where providers work together to provide high quality care to Medicare enrollees, who are typically part of underserved populations. The King County Hospitals for a Healthier Community (HHC) has members that are academic medical centers, accountable care organizations, and members of an Accountable Communities of Health in Washington state. Although the King County Accountable Communities of Health transformation projects were not studied as part of this evaluation, they address priorities identified in the most recent King County HHC CHNA.

The majority of health department partners at the case study sites are responsible for collecting the primary and secondary data used in the assessment and planning components of the CHI process. Five of the health departments were accredited by the Public Health Accreditation Board and three others were undergoing the accreditation process during the time of their site visits. A key component of accreditation is demonstrating a high CHI process standard, including a collaborative community process.

FIGURE 1: Geographic Location of Participating Case Study Sites



TABLE 1: Characteristics of 10 Case Study Sites

Structure of the Collaborative	Hospital Led	4
	Community Led	1
	Mixed Leadership	5
	501c3	2
Hospital Partner Characteristics	Academic Medical Center	6
	Accountable Care Organization	5
Health Department Partner Characteristics	Responsible for data	7
	Accredited	5
	Accreditation in progress	2
	Not currently seeking accreditation	3
Length of Time Functioning as a Collaborative	6 to 10 years	5
	More than 10 years	5
Other	Accountable Health Community	1

What We've Been Learning: Themes Across Sites

CHI Process Alignment and Collaboration

Among the CHI processes, we found extensive coordination and alignment among collaborative partners around some steps of the CHI process and less coordination and alignment related to others. Based on the Association for Community Health Improvement Community Health Assessment Toolkit (see **Figure 2**), the 10 CHI processes we examined had strong alignment and coordination in Steps 1-6 of the toolkit framework. With regard to steps 7-9, which include planning and implementing strategies to address prioritized needs and monitoring and evaluating those strategies, we saw minimal or inconsistent alignment. All of the sites examined community needs related to the social determinants of health by looking at root causes or “upstream” factors that affect priority health needs. Later in this document, we provide examples of how sites are addressing these root causes.

Alignment Facilitators

Collaborative members identified six *facilitators* that supported the alignment of efforts to address community health needs, as detailed below.



Facilitator 1: Creating a collaborative structure that met the local context

Each of the 10 collaboratives was built upon a history of collaboration in their communities, which was essential to creating a backbone structure that “fit” their needs. As shown in **Table 1**, these sites used a variety of backbone structures. Rather than identifying a single “ideal” backbone structure, we found that the structure that best fits a community’s needs is ideal. Among collaboratives that have been in place longer, structures have evolved over time to meet the changing needs of collaborative members and requirements from federal and

FIGURE 2: ACHI Community Health Improvement Toolkit Framework



STEPS 7-9:
Inconsistent or Minimal Alignment Among Collaborative Members

STEPS 1-6:
Strong Alignment Among Collaborative Members

state entities and health department accreditation. Several sites emphasized the collaborative nature of their communities as a support for aligning their work, whereas others, particularly smaller sites, noted that hospitals have developed a shared understanding of where they can collaborate and where they will compete.

“When I go into small counties, I often find that they have a multitude of different coalitions – a diabetes coalition and a safe kids coalition and there will just be a billion of them. And they tend to have the same people coming to each one and you tend to see people just get worn out so the coalition will stumble or completely disband because just can’t do one more meeting. So, what I like is having the overarching coalition, a health-centered, health overall coalition and then having it break into workgroups by topic.”

— **HEALTHY CHOICES,
HEALTHY COMMUNITIES INTERVIEWEE**



Facilitator 2: Collaborating to address multiple requirements to assess community needs.

Hospitals, health departments, and community organizations (e.g., United Way) have simultaneous, overlapping requirements to assess and address community needs. Collaborative members at the case study sites have joined together to address the various assessment requirements and reduce effort duplication. In some sites, community organizations and residents created a sense of urgency for assessment coordination and, in other sites, the hospitals and other agencies initiated shared efforts to save costs and use local resources, such as health department data capabilities.

“It’s not just the relationships between two hospitals and RiverStone. Billings is a very collaborative town and people know each other. The CEO of United Way has been here 15 – 20 years, we know people who run social service agencies, food banks. There’s a very different sense of importance of collaboration here...when it comes down to getting work done, [the] community is too small to have a lot of tables.”

— **HEALTHY BY DESIGN INTERVIEWEE**

“We realized we were tapping the same community organizations, individuals at hospitals and PHSKC [Public Health Seattle & King County] for data. We have our own tailored needs around data. There was a lot of duplication. We were tapping the same people, so we wanted to think about how we could have less burden.”

— **KING COUNTY HEALTHIER HOSPITALS
COLLABORATIVE INTERVIEWEE**

“The CCH [Center for Community Health] was viewed as the neutral convener, despite their affiliation with the University of Rochester, which is part of one of the two participating health systems. CCH was described as “Switzerland,” a “neutral presence,” and a “neutral party,” and it was noted that “people view this [the CHNA and CHIP] as a County project, not CCH. [The health] systems view it as Monroe County.”

— **MONROE COUNTY INTERVIEWEE**

Several Monroe County interviewees also noted that having the local health department serve as “a neutral source of data” is beneficial for ensuring a collaborative, data-driven process.



Facilitator 3: Using multiple approaches to meet assessment requirements.

As shown in **Table 2**, collaborative members work together to meet assessment requirements for their various members, but the collaboratives meet these requirements in different ways.

- **Partially Shared Assessment and Planning Models:** Four sites use a partially shared model where the data collection, selection, and prioritization processes to inform requirements is shared among partners. Beyond this shared effort, partners conduct additional individual data collection as needed to inform their own work or meet various requirements. They also prepare separate, tailored reports for specific audiences. Additionally, collaborative members prepare their own improvement planning documents. For example, the Rutland Regional Medical Center shared CHI process provides, in the words of one focus group participants, a “*broad-level assessment for others to jump off of and do a deeper dive.*”



- **Fully Shared Assessment and Planning Models:** Six sites share all aspects of the assessment, including data selection and collection, prioritization of issues, and preparation of an assessment and prioritization document.

“A lot of it is the resource availability. We’re a small health department — we only serve about 11,000 citizens and the county only has about 54,000. So, a lot of times the city and county will get involved in those coalitions to see what resources we can get because we don’t have the resources or the means to get data.”

— **BON SECOURS INTERVIEWEE**



Facilitator 4: Creating implementation strategy approaches that fit the context

Following assessment and prioritization, sites use three approaches to implement strategies to address prioritized needs (Also shown in **Table 2**).

- **Limited Shared Implementation:** Three sites use a limited shared implementation model in which collaborative members address between one and three priorities jointly while the partners address other needs separately. For

example, although the Healthy By Design 2016-2017 CHNA identified three health priorities (mental health; nutrition, physical activity, and weight; and substance abuse), the 2017-2020 CHIP is focused on two linked priorities: physical activity and nutrition. As one interviewee stated, Healthy By Design went from a “*three-legged stool to one pillar*.” The Healthy By Design backbone committee chose this approach to deploy its limited staffing effectively while leveraging community resources to address the other priorities (i.e., The United Way of Yellowstone County is addressing substance use within the community).

The University of Pittsburgh Medical Center (UPMC) Children’s Hospital partners, most notably the Pittsburgh Public Schools, employed a highly coordinated strategy to address their priority issue: to create healthy schools and students. The implementation strategy uses an ecological approach to promote policy, systems, and environmental change, as well as address student clinical needs.

- **Fully Shared Implementation:** Four sites use a model in which all partners jointly address all prioritized needs through work groups or informal subgroups. In an effort to maximize resources, Cecil County partners have found that fully shared implementation has also strengthened their collaboration and ability to leverage resources.

TABLE 2: Case Study Site Approaches to Assessment, Planning, and Implementation

SITE	ASSESSMENT & PLANNING MODEL	IMPLEMENTATION APPROACH
Bowse County (VT)	Partially Shared	Limited Shared
Cecil County (MD)	Fully Shared	Fully Shared
Healthy Baton Rouge (LA)	Partially Shared	Distributed
Healthy by Design (MT)	Fully Shared	Limited Shared
Healthy Choices (KY)	Fully Shared	Fully Shared
Health Collaborative of Bexar County (TX)	Fully Shared	Fully Shared
King County Healthy Hospital Collaborative (WA)	Partially Shared	Distributed
Monroe County Community Health Improvement Workgroup (NY)	Fully Shared	Distributed
San Francisco Health Improvement Partnership (CA)	Fully Shared	Distributed
UPMC Children’s Medical Center (PA)	Partially Shared	Limited Shared

“We need to pool, not pull, limited resources. We’ve been able to find [opportunities] to galvanize efforts.”

— **CECIL COUNTY COMMUNITY HEALTH ADVISORY COMMITTEE INTERVIEWEE**

Meanwhile, the Bexar County CHIP outlines indicators that collaborative workgroups identified using the Results Based Accountability framework. Each indicator is directly related to an identified need in the CHNA.

“Everything we do has to fit a strategy under the five core areas of the CHIP.”

— **BEXAR COUNTY HEALTH COLLABORATIVE INTERVIEWEE**

- *Distributed Implementation:* Four sites use a model in which the partners address prioritized needs in self-organized subgroups (i.e., separate from the collaborative) or conduct their own implementation efforts.

“Activities in the implementation plan are largely reflective of what hospitals and community organizations are already doing under the four priority areas, with the

implementation plan serving as an opportunity to coordinate, support, and share resources amongst partners.”

— **HEALTHY BATON ROUGE INTERVIEWEE**

“Maybe that’s a role for SFHIP [San Francisco Health Improvement Partnership], as more of an umbrella organization... to serve a linkage function and help enhance those connectivities. We need to think strategically – there’s no way for it to be the driver of collective impact, but it could be the convener.”

— **SFHIP INTERVIEWEE**



Facilitator 5: Maximizing data resources.

According to collaborative members, data resources are becoming more useful and informative than they once were. For example, data sets that are available at the zip code or census tract level can be used to identify geographic areas of greater need in a community, as well as areas where there are disparities in health and social determinants of health. Additionally, these resources can provide measures for monitoring the effectiveness of implementation strategies.

FIGURE 3: Example objectives, Healthy By Design, 2016

IMPROVEMENT PLAN OVERVIEW

VISION	
Make the Healthy Choice the Easy Choice	
OVERALL APPROACH	
Healthy By Design, through policy, systems and environmental change efforts will see a positive effect in Yellowstone County’s physical, behavioural and social wellbeing related to physical activity, nutrition and overall health.	
LONG-TERM MEASUREMENT GOAL	
Increase proportion of residents who are at a healthy weight in Yellowstone County by 10% to 35.3% by 2030.	
OBJECTIVES	
(no particular order — additional related data available in the CHNA)	
Increase in reported consumption of 5 servings/day of fruits and vegetables among Yellowstone County residents from 30.8% to 33.88% by 2020.	Increase in reported children who are physically active for 1+ hours/day in Yellowstone County from 70.8% to 77.8% by 2020.
Increase proportion of adults reporting leisure time physical activity in Yellowstone County from 82% to 90.2% by 2020	Increase in reported Yellowstone County adults whose activities are not limited in some way due to a physical, mental, or emotional problem from 70.4% to 77.44% by 2020

“We’ve be able to use data to invest in our major initiative of 211. That wouldn’t have happened if it hadn’t been identified by other community leaders and the data showing where we should be investing.”

— **HEALTHY CHOICES, HEALTHY COMMUNITIES COALITION INTERVIEWEE**



Facilitator 6: Monitoring implementation strategies and health outcomes

Four sites have developed measures for population-level goals and objectives that follow SMART criteria (Specific, Measurable, Actionable, Relevant, Time-Bound). For example, to address the healthy weight pillar, the Healthy By Design Community Health Improvement staff convenes workgroups comprised of non-profits, social services agencies, and other community organizations. Workgroups coordinate and monitor progress on the improvement strategies to achieve the identified objectives (see **Figure 3** above).

Several case study sites are monitoring implementation strategies using clear metrics that identify the parties accountable for achievements. Development of these strategies occurs primarily in sites where collaborative members jointly address prioritized needs through coordinated efforts. For example, the Cecil County Community Health Improvement Plan includes measurable objectives for each goal under each of the three priority areas. Additionally, the Tobacco, Cancer and Healthy Lifestyles Task Forces have developed workplans with short-term objectives, and a rubric to track actions and progress towards these objectives.

Alignment Challenges

Collaborative members also identified seven challenges to aligning efforts or opportunities to improve how members work together.



Challenge 1: Clarifying structure, capacity, focus, and strategy.

Collaborative members are looking for additional structure, capacity, and resources to advance the work of the collaborative. Further, several collaborative members suggested clarifying what could be achieved through the collaborative, particularly the extent to which collaborative members have a collective will to implement joint improvement strategies. They also suggested identifying more systematic ways to engage with each other around initiatives.

“I think people care, but I think there needs to be a better structure. Whether that’s bylaws or people come and feel like they don’t play role and they weed out over time. I think we have data and meet and meet and meet and that’s good, but we need more of a structure.”

— **HEALTHY CHOICE HEALTHY COMMUNITIES (HCHC) INTERVIEWEE**



Challenge 2: Increasing accountability.

Collaborative members from several sites identified the need to increase member accountability throughout the CHI process and, more specifically, accountability for implementing strategies to address prioritized health needs. As part of accountability, some collaborative members identified a need for increased leadership among members so that everyone at the table has a voice and those voices are coordinated.

“I think it would be helpful to know what the individual goals and needs are around the table and looking at that with the CHNA to see where the best fit is. If you’re not held accountable for it, it just gets put on the back burner. It would be interesting to see the what’s in it for me, as well as looking at the community and city at large.”

— **SFHIP INTERVIEWEE**

In the **Monroe County site**, one interviewee wondered why the CHIW (Community Health Improvement Workgroup) doesn’t have “*more power to get things done*,” and noted that despite approvals of the CHNA and CHIP by hospital boards, the CHIW lacks “*authority*” to enforce implementation of identified strategies. Another interviewee noted that there should be “*some sort of accountability for not moving the needle*” if the CHNA and CHIP process are completed and then “*shelved*” until the next process three years ahead.





Challenge 3: Engaging appropriate organizational stakeholders.

Collaborative members described the need to create structure that encourages stakeholder engagement at appropriate organizational levels. Specifically, they identified the need for individuals at the same organizational level (e.g., directors or managers) to attend the same meetings to support more efficient decision-making by the collaborative, as well as address challenges in power dynamics among collaborative members.

“[The] challenge is that there are different levels of power among partners at the table. Some people are empowered with budget and some aren’t in charge of anything. No judgment there, but you can’t use that group to make big decisions and action.”

— KING COUNTY HOSPITALS FOR A HEALTHIER COMMUNITY COLLABORATIVE INTERVIEWEE



Challenge 4: Engaging new partners: the business sector.

While the partners in many of the sites represent a broad array of community sectors (e.g., schools, police, parks and recreation), members identified a need to engage sectors that can influence economic development, such as chambers of commerce and businesses.

“We really haven’t included other types of business influencers, integration of the chamber of commerce, particularly around economic development and the effect on health.”

— HEALTHY BATON ROUGE INTERVIEWEE



Challenge 5: Increasing resources.

Regarding capacity, members at several sites observed that staff in backbone organizations — whether a single or distributed backbone — were stretched too thin. Adding more staff and supporting staff with other resources were seen as specific needs. And, as with many community

health improvement efforts, collaborative members identified the need for additional financial resources to support their core work, in addition to resources for specific improvement efforts.

“Small organization, operations, miracle of [THC Executive Director]. [She] knows everyone, energetic, and wants to help. THC could use funding to do more programming, a lot of THC’s work depends on unpaid labor.”

— THE HEALTH COLLABORATIVE OF BEXAR COUNTY INTERVIEWEE



Challenge 6: Obtaining more useful data.

While data availability is seen as a facilitator at some sites, others viewed it as a major challenge, particularly at sites experiencing data lags where available data are not typically current to a specific assessment cycle. Additionally, not all data are available below the county level, especially health behavior and health outcome data. The lack of timely and specific data can impede a collaborative’s ability to identify priority health needs within neighborhoods. As noted in the recent County Health Rankings, there are disparities in life expectancy within metropolitan areas at the zip code level. The ability to obtain such highly detailed data can facilitate prioritization of health needs and provide guidance for implementing strategies where resources are most needed.

“Challenge for indicators is that not all are collected annually or are not stratified by race, ethnicity, age, and not all are available with an equity lens.”

— SFHIP INTERVIEWEE



Challenge 7: Addressing implementation, monitoring, and evaluation.

As seen in **Figure 2** above, there is less alignment of effort in implementation, monitoring, and evaluation (steps 7-9) than in the initial CHI process steps (1-6). Collaborative members identified challenges to the implementation, monitoring, and evaluation of their CHI efforts, all of which are related to the IRS regulations in some way.



- With the three-year cycle in the IRS requirements, there is constant pressure to get ready for the next assessment. One site, SFHIP, addressed this pressure by doing an “assessment of assessments” for the 2016 cycle. Rather than conducting a full city-wide health needs assessment, SFHIP reviewed recent health assessments and identified communities where additional data were needed to assure appropriate prioritization of needs and to identify strategies to address those needs.
- The IRS does not require specific efforts toward implementation, monitoring, and evaluation and that the requirements that do exist are vague and offer little guidance.
- Finally, the IRS requirements are still relatively new. While collaboratives have made progress in aligning their assessment and planning efforts, they have not had sufficient time to align their implementation, monitoring and evaluation components. In other cases, collaborative members have been working since before the IRS regulations were released. In such cases, structures may exist that minimize shared implementation, monitoring, and evaluation. For example, individual institutions may have a history of joint assessment followed by separate implementation of strategies. The King County Healthier Hospitals Collaborative began with hospitals conducting joint assessment activities before the final IRS regulations were released. The final IRS requirements, however, were the catalyst for the current, more robust CHNA process. But, as one interviewee said, *“Every hospital is so unique that we won’t give up the priorities that we have had historically.”* Therefore, the members of this collaborative have, to date, focused shared efforts on the CHNA steps of the process.



Demonstrating Promise for Improvement

Each of the 10 sites has made progress related to their implementation strategies; some have been able to show measurable results. In this section, for each case study site, selected achievements are described that demonstrate the promise of their CHI processes for improving population health and health equity in their communities.

Healthy Baton Rouge: Improving Nutrition and Physical Activity

The Mayor's Healthy City Initiative was awarded a Challenge Grant from the Blue Cross Blue Shield of Louisiana Foundation to lead Fresh Beginnings, designed to increase access to healthy food in targeted neighborhoods. The project included a mobile farmers market, convening a Food Access Policy Commission, and partnering with schools to increase nutrition education and physical activity opportunities, including new exercise equipment in four elementary schools. BREC on the Geaux is operated by the Baton Rouge Parks and Recreation Department and provides mobile playgrounds that bring opportunities for physical activity to schools or neighborhoods that may not otherwise have them.

Healthy by Design: Complete Streets as Health Equity

In 2011, led by Healthy By Design, the Billings City Council adopted a Complete Streets policy. However, in 2016, with the election of new city council members, the policy and specifically road set asides and bike lanes were being reconsidered. Healthy by Design activated its coalition membership to reframe the issue and underscore the importance of the policy for the whole community and not just for “*spandex-clad bikers or marathoners.*” At that time, Healthy By Design's work groups that focused on mental health and high health care utilizers identified patients with lived experience who could speak to the importance of Complete Streets and emphasized the implications for accessing employment and groceries, thus framing Complete Streets as a health equity issue. The hospital CEOs, recognizing that the policy is attractive to their employees, had additional incentive to sign on to the initiative. With leadership from Healthy By Design, the community rallied around the Complete Streets policy, including “*families who appreciate sidewalks*” and “*doctors who chose Billings for accessibility*” and the policy remained in place. Healthy By

Design partners suspect that the implementation of the Complete Streets approach may have contributed to achieving and surpassing some of the 2014-2017 implementation plan targets, specifically the proportion of adults reporting no leisure-time activities and the proportion of children who are physically active for one or more hours per day.

Cecil County: Peer Recovery Advocates Addressing Substance Use Disorders

One example of success that grew out of the CHI collaboration between the hospital and health department was the development of the Peer Recovery Advocates program. During the 2012-2013 CHNA, a county-wide focus on substance abuse issues emerged. Following a comprehensive assessment specific to substance use disorders, a number of programs emerged including the Peer Recovery Advocates, a collaboration of the health department, hospital, and community. The Division of Addiction Services within the Cecil County Health Department spearheaded the development of the program, which is funded through the county and the state and embeds Peer Recovery Advocates at the Union Hospital Emergency Department and throughout the community (e.g., at health centers and jails). The Peer Recovery Advocates are available to engage with individuals that may have substance use issues and connect them with available resources. The health department staff worked closely with Union Hospital staff to develop tools and processes for this program and the Union Hospital Community Benefits Coordinator facilitated connections to help the program “*blossom.*”

King County Hospitals for a Healthier Community Collaborative: Coverage is Here King County

Hospitals for a Healthier Community (HHC) members agreed to address access to health insurance as a shared priority. HHC members then partnered with other organizations



on the Coverage Is Here King County campaign to enroll community members in qualified health plans. For example, Public Health – Seattle & King County or PHSKC developed a network of enrollment navigators who offered enrollment assistance at libraries, food banks, and other public places in communities with the highest rates of uninsured residents. These cooperative efforts paid off. After ACA implementation in 2014, lack of insurance among the unemployed dropped from 42.8% in 2013 to 18.8% in 2016.

Monroe County Community Health Improvement Workgroup: Tobacco Use Quitline

The Community Health Improvement Workgroup (the CHIW) is used by the four counties that serve Monroe County, New York. Four hospitals implemented the Quitline to address the collaborative's Tobacco Use priority. All hospitals that participate in the CHIW committed to changing their electronic health record systems so that any time a patient indicates s/he is a current smoker, the electronic health record automatically sends the patient's information to the statewide Quitline (unless the patient opts out). One case study interviewee noted that seeing the *“Quitline referral numbers incrementally increase as our hospitals come on”* made this individual think, *“Wow it's really working!”*

Rutland Regional Medical Center: Addressing the Health of the Community

to its participation in the CHI process, Rutland Regional Medical Center has begun to define its role in community health, including making an important change to its mission statement. The current medical center mission statement begins with the clause “To improve the health of the Rutland Region and surrounding communities”; one leader noted *“the ‘health of the community’ part came out of CHNA processes and our belief that the world was changing as we move into [the] population health world.”*

San Francisco Health Improvement Partnership: Policy Wins

Through collaborative work, the San Francisco Health Improvement Partnership has achieved several policy goals that promote community health. First, through regulation and institutional policy change, partners reduced the availability of sugar-sweetened beverages in government buildings,

hospitals, and school district facilities. Second, working with a variety of partners that included police and technology industry non-profits, the collaborative engaged community organizations and policy makers to prevent the sale of powdered alcoholic beverages at the city and state-levels and prevented the sale of alcohol at food and beverage retailers.

University of Pittsburgh Medical Center Children's Hospital: Partnering with Public Schools

Children's Hospital and Pittsburgh Public Schools have seen success with the implementation of the Healthy Schools Program. Through the partnership, the entire district has adopted the “Smarter Lunchrooms” program, part of the Healthy School Programs which “promotes healthy food and beverage choices” in school cafeterias.

Healthy Choices, Healthy Communities Coalition: Increasing Access to Services

The access to care group of the Healthy Choices, Health Communities Coalition implemented a 2-1-1 service (i.e., helpline) in partnership with the United Way to increase awareness of and access to services that are available in the tri-county area. This partnership with the United Way is seen as a success on two fronts: As a strategy to address the priority area of access to care and in the collection of data that could be used to direct future work or funding.

Bexar County Community Health Collaborative: Health Improvement through Multiple Strategies

The Bexar County Community Health Collaborative was initially created to develop a shared CHNA for member hospitals and health systems. With the implementation of the IRS community health assessment and improvement process requirements for not-for-profit hospitals, the shared CHNA still serves as a primary driver for shared efforts. More recently, collaborative members have been working with community partners to improve community health in priority areas identified in the CHNA, including social determinants of health. The collaborative is building the Grow Healthy Together Pathways Community HUB, which will connect community members to resources that address their health and social needs.





Summary

We found that CHI processes included in the case studies are improving alignment of efforts and resources within their communities. Alignment is facilitated by developing infrastructures that meet the context, needs, and will of the partners. The shared assessment and prioritization efforts reviewed varied regarding implementation of shared approaches to address priority health needs and, to date, have demonstrated limited effort in measurement, monitoring, and evaluation. Through a variety of structures, these collaboratives create, support, and participate in community engagement efforts.

Finally, these collaboratives are demonstrating promise to community and population health through implementing strategies that address social determinants of health to reduce health disparities and by implementing policy, systems, and environmental strategies that impact the health of the whole community.

Appendix: Project Background and Methods

Background

The Internal Revenue Service (IRS) Community Health Needs Assessment (CHNA) requirements, especially the implementation strategies for non-profit hospitals, have the potential to refocus healthcare efforts “upstream” to address the social and behavioral determinants of health. These requirements, along with the increasing prominence of performance management in the healthcare delivery sector, are intended to encourage this sector to be accountable for health outcomes in defined populations.

While the IRS discusses “CHNAs” in the form of community health needs assessments and strategic implementation plans, this requirement implicitly includes the entirety of the community health improvement process: *assessment, planning, implementation of initiatives, and monitoring and evaluation (hereafter, CHI processes)*. Although the IRS guidelines allow hospital institutions to conduct these processes with minimal involvement of other community organizations, best practices in public health and the convergence of simultaneous assessment and planning guidelines for other entities (e.g., the Public Health Accreditation Board for health departments) have encouraged the field to use a more collaborative approach with other institutions and community partners to improve community health.

Despite the number of models being developed by hospitals and communities, the extent to which the community health improvement process has helped align initiatives, foster organizational collaboration and coordination, and ultimately improve population health outcomes is unclear. With support from the Robert Wood Johnson Foundation, Health Resources in Action (HRiA), is conducting a project with the **principal objective** to increase understanding of the characteristics of CHI processes, employed by hospitals and their community partners, that have promise (via evidence) to improve health equity and outcomes.

With nearly 3,000 not for profit hospitals in the U.S. it is not practical or feasible to evaluate all hospital CHI processes. Nor is it feasible to evaluate the more than 100 that were identified as exemplary in previous reviews of hospital collaborative processes. Instead, a systematic approach is needed to identify CHI processes that are most likely to yield the desired outcomes.

Methods

HRiA used the Systematic Screening Assessment (SSA) approach to identify sites ready to participate in the evaluation. This approach focuses limited evaluation resources on practice-based innovations that are most likely to demonstrate desired outcomes. SSA is a stepped approach that narrows and focuses examination of innovations from an entire field, where innovations could number in the hundreds, to approximately 10-15 that are ready for evaluation. The SSA approach maximizes evaluation resources to yield meaningful learning by participating organizations and information useful to a larger group of stakeholders (*Leviton, et al. 2010*).

Working with an Advisory Panel, that included diverse representation from non-profit, government, academic, and professional membership organizations, inclusion criteria for CHI processes for this project were defined as follows.

- Site implements a single, grounded, and **collective process** that integrates hospital, health department, and community priorities, including identifying the root causes and social determinants of health problems within a community
- Process includes full, **broad community engagement**
- **Intended outcomes** (including reduction of inequalities and inequities) are **clearly defined**
- Out of the assessment come clear, focused, **measurable objectives and outcomes**, including outcomes that address health inequities
- Outcomes are realistic and addressed with **specific action plans** designed to eventually improve population health, including reducing inequities
- Plans become **fully integrated into agencies** and become a way of being for the agencies

The project team used multiple approaches to identify processes for review, including expert opinion, database review, and reports or grey literature. In the first round of review, project staff applied Advisory Panel criteria using multiple scenarios to ensure accurate coding on inclusion criteria. The primary focus of this first round was to apply the criteria of a single process in the community and broad community engagement to each CHI process. At least two different staff reviewed each CHI process.



TABLE 1: Reason for Community Health Improvement Process Exclusion and Number Excluded

REASON FOR EXCLUSION	NUMBER EXCLUDED
No hospital involved	4
Hospital became a for profit entity	1
Hospital closed	1
Single hospital process without collaboration with other entities	26
Insufficient information publicly available	9
TOTAL	41

In total, we reviewed 124 processes representing 514 hospitals. Of these, 83 sufficiently met the primary inclusion criteria and 41 did not. **Table 1** above presents reasons for excluding specific CHI processes. The attached infographic provides additional information on this process.

In the second round of review, staff re-applied Advisory Panel criteria focusing on the remaining criteria, with one exception—the extent to which implementation plans are becoming fully integrated into hospitals - as there was little evidence publicly available related to this criterion. Of the 83 processes reviewed, 59 met the additional criteria and 24 did not.

As part of the review cycles, project staff examined characteristics identified in the literature as likely to affect collaborative processes and outcomes, including geography, urbanicity, and whether the state in which the process occurred expanded Medicaid and had CHI requirements for non-profit hospitals prior to implementation of the Affordable Care Act. In addition, project staff divided processes into categories according to the type of collaboration. We used the hospital as the starting point to categorize the type of collaboration and identified the following categories: 1 hospital, 1 hospital system, multiple hospital collaboration (single hospitals and hospital systems), Collaborative Process (multiple hospitals and additional partners), and Community-Led Collaborative. Using these categories, we were able to place hospitals in mutually exclusive categories. Additional characteristics, such as whether the hospital or hospital system is part of an Accountable Care Organization, were also considered during the review.

Table 2 presents characteristics of the 59 hospitals that met the additional criteria, as well as subsets of 20 identified as priorities for inclusion in the case studies. Project staff identified 20 sites based on clear evidence of meeting all inclusion criteria with a priority focus on addressing root causes of health problems and available data to measure progress towards improving health outcomes. Among these sites, project staff, with input from the Advisory Panel, identified 10 as being high priority to invite to be case study sites to achieve a mix of sites by the characteristics presented in **Table 2**, with a focus on recruiting sites that varied by type of collaboration, geography, and urbanicity.

Project staff conducted screening calls with the 10 priority sites to determine if participation as a case study site would be appropriate from both a project perspective and a site perspective. Through these calls, staff verified publicly available information, as well as site interest in learning from an evaluation and capacity to participate in an evaluation that included a multi-day site visit. Two sites determined that participation was not appropriate from the site’s perspective and a third site did not complete the screening process. Project staff replaced these sites with other sites with similar characteristics from the pool of 20 sites.

Following data collection, the project team further refined the focus of the site characteristics based on site visit observations. Refined characteristics include streamlined Structure of the Collaborative categories, including hospital led, community led, mixed leadership, and led by a non-profit 501(c)3 organization. Added characteristics included specific characteristics of hospital and health department partners, as well as length of time functioning as a collaborative.

TABLE 2: CHI Process Characteristics

		Round 2.1 n=59	Round 2.2 n=20
Type of Collaboration	1 Hospital	6	3
	1 Hospital System	7	3
	Multiple Hospital Collaboration	5	2
	Collaborative Process (multiple hospitals and additional partners)	15	5
	Community-Led Collaboration	26	7
Geography	Northeast	13	8
	South	18	7
	Midwest	16	2
	West	12	3
Urbanicity	Mostly Urban	41	15
	Mostly Rural	6	2
	Mix of Mostly Urban & Rural	12	3
Medicaid Expansion	State Expanded Medicaid	43	14
	State Did Not Expand Medicaid	16	6
CHI Requirements	CHI Requirement in State pre-IRS regulations	17	7
	No CHI Requirement in State pre-IRS regulations	42	13

Site visits occurred from October 2017 through March 2018 and included interviews with key informants, focus groups with community partners, and observations of collaborative meetings. Key informants included project staff and representatives of founding or sponsoring organizations. Staff used standard guides for interviews and focus groups to ensure key topics from the research questions were covered. HRiA project staff took notes of each interview and focus group.

The project team created a standard site report outline to present and discuss data to inform research questions and topics of interest. Information for each site report was obtained from site CHI process reports, including CHNA and implementation plan documents, qualitative data from interviews and focus groups, and observations of CHI process meetings.

Qualitative Analysis Methods

Qualitative data were analyzed with NVivo 11 Pro software. Interviews and focus groups were coded using a conventional content analysis methodology (H-F. Hsieh and S. Shannon, 2005) to identify salient themes and sub-themes. Initial codes were created in NVivo and then collapsed into parent and child categories following the completion of coding. Coding queries were run by site location to produce site specific coding reports.

Sites reviewed a draft report of their own case study findings to correct any errors and provide insights about the results. Dissemination of the site-specific report is at the discretion of each site.

Cross Site Analysis

The cross-site report summarizes themes identified through review of case study site themes, staff observations, and discussion with Advisory Panel members and staff from case study sites. We conducted additional analysis of qualitative data to validate observations and discussions. Specifically, we examined what sites perceived as working well and areas for improvement within each of the CHI process steps (assessment, prioritization, planning, implementation, and monitoring and evaluation). Using coding from individual site analyses, we identified patterns across sites within this matrix and explored patterns among sites serving smaller populations (< 100,000), medium populations (100,001-500,00) and large populations (> 500,001).

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