Community Health Assessment and Community Benefit:
An Opportunity for Collaborations

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Northern Kentucky Health Department

July 11, 2012

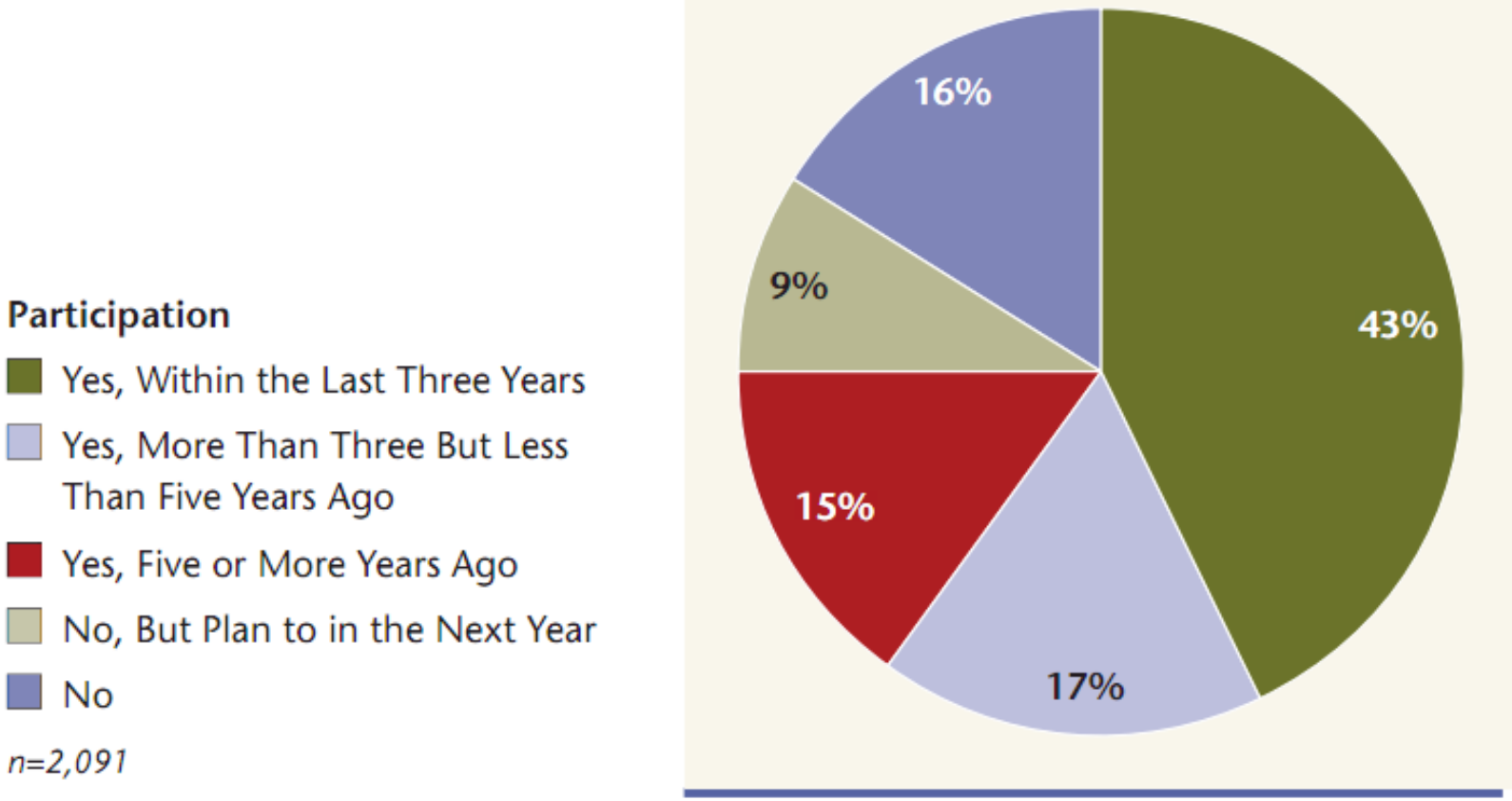
Public Health
Prevent. Promote. Protect.

NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

Introduction

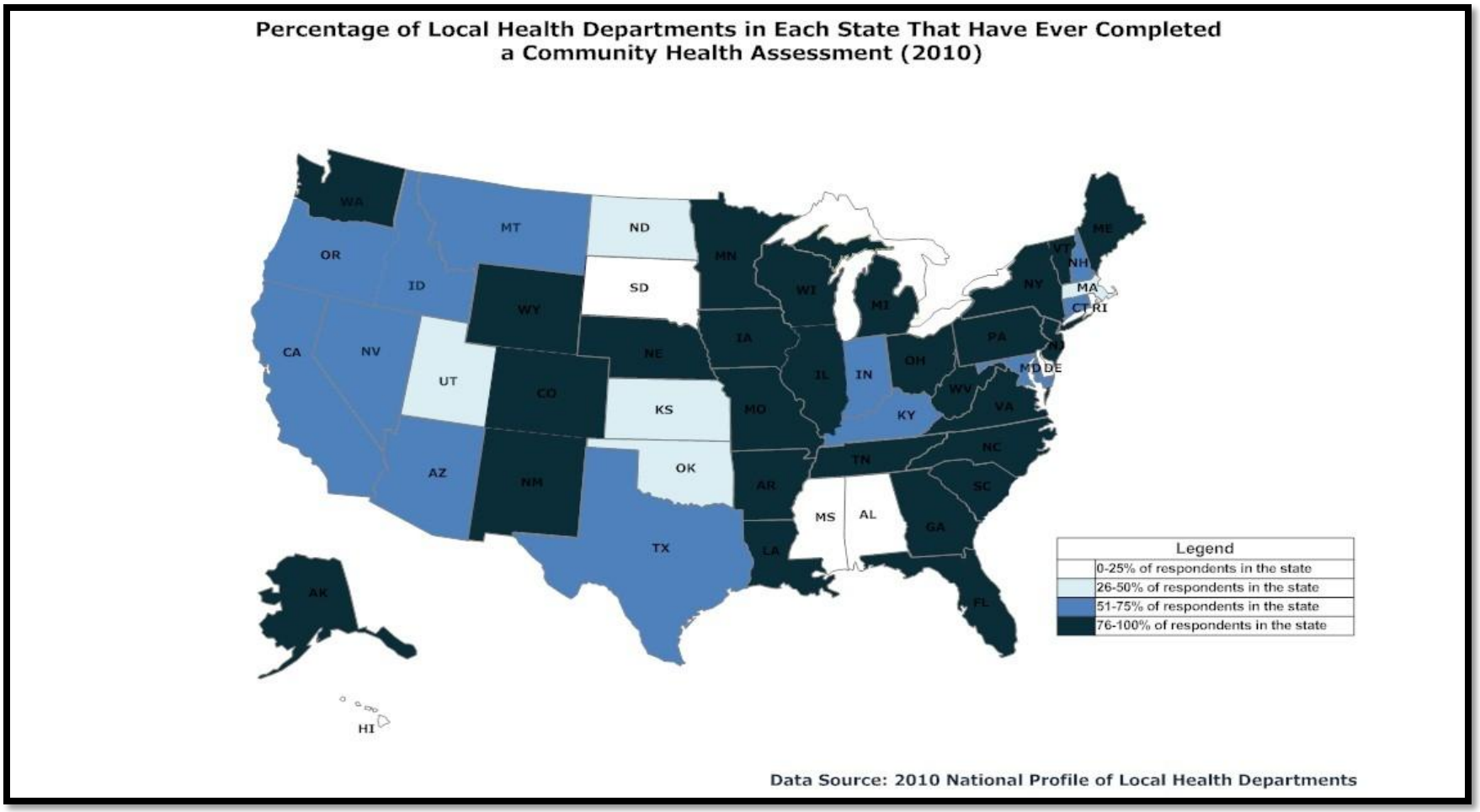
- Local health departments have a background in community health assessment.
- Recent community health assessment emphasis:
  - Voluntary National Accreditation for LHDs
  - 2010 ACA Community Benefit for nonprofit hospitals
- Economic pressure:
  - Greater need to conserve resources, work together in collaborative models
- More national emphasis on prevention strategies

FIGURE 8.1 | Percentage Distribution of LHDs, by Participation in Community Health Assessment



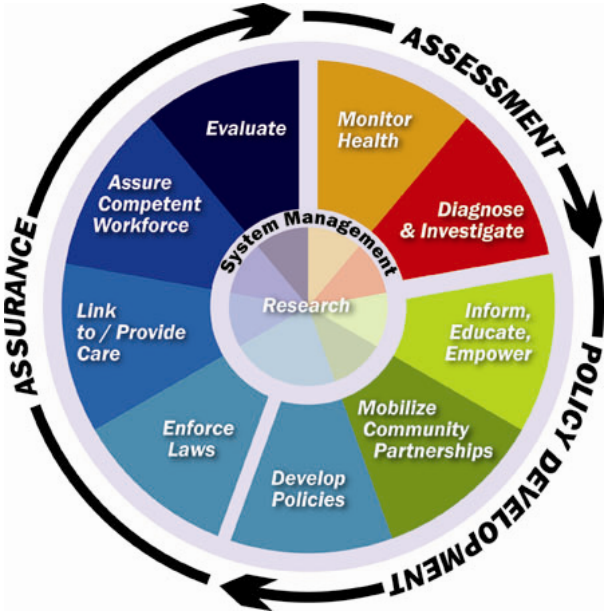
Data Source: 2010 National Profile of Local Health Departments

Community Health Assessment Activity



Voluntary Accreditation Preparation

- http://www.phaboard.org/
- Health department must provide documentation of a *collaborative* process
- Community health improvement planning strategies should be evidence-based or promising practices



Standard 1.1: Participate in or conduct a collaborative process resulting in a comprehensive community health assessment.

Measure	Purpose	Significance
1.1.1 T/L Participate in or conduct a Tribal/local partnership for the development of a comprehensive community health assessment of the population served by the health department	The purpose of this measure is to assess the health department's collaborative process for sharing and analyzing data concerning health status, health issues, and community resources to develop a community health assessment of the population of the jurisdiction served by the health department.	The development of a Tribal/local level community health assessment requires partnerships with other members of the Tribe/community to access data, provide various perspectives in the data analysis, present data and findings, and share a commitment for using the data. Assets and resources in the Tribal/local community should be addressed in the assessment, as well as health status challenges. Data are provided from a variety of sources and through various methods of data collection.

3. Description of the process used to identify health issues and assets	3. The health department must provide documentation of the collaborative process to identify and collect data and information, identify health issues, and identify existing Tribal or local assets and resources to address health issues. The process used may be an accepted state or national model; a model from the public, private, or business sector; or other participatory process model. Examples of models include: Mobilizing for Action through Planning and Partnership (MAPP), Healthy Cities/Communities, or Community Indicators Project. Examples of other tools and processes that may be adapted for the community assessment include: community asset mapping, National Public Health Performance Standards Program (NPHPSP), Assessment Protocol for Excellence in Public Health (APEX/PH), Healthy People 2020, and Protocol for Assessing Community Excellence in Environmental Health (PACE-EH).

Standard 5.2: Conduct a comprehensive planning process resulting in a Tribal/state/community health improvement plan.

Measure	Purpose	Significance
5.2.1 L Conduct a process to develop community health improvement plan	The purpose of this measure is to assess the local health department's community health improvement process and the participation of stakeholders.	While the local health department is responsible for protecting and promoting the health of the population, it cannot be effective acting unilaterally. The health department must partner with other sectors and organizations to plan and share responsibility for community health improvement. Other sectors of the community and stakeholders have access to additional data and bring different perspectives that will enhance planning. A collaborative planning process fosters a shared sense of ownership and responsibility for the plan's implementation. The community health improvement process is a vehicle for developing partnerships and for understanding roles and responsibilities.

1. Completed community health improvement planning process that included:	1. The local health department must provide documentation of a completed community health improvement planning process. The process may be an accepted state or national model; a model from the public, private, or business sector; or other participatory process model. Examples of models include: Mobilizing for Action through Planning and Partnership (MAPP), Healthy Cities/Communities, or Community Indicators Project. Examples of tools and processes that may be adapted as a planning process or used for particular components of the planning process include: community asset mapping, National Public Health Performance Standards Program (NPHPSP), Assessment Protocol for Excellence in Public (APEX*PH*), Healthy People 2020, and Protocol for Assessing Community Excellence in Environmental Health (PACE-EH).

A sign of the (economic) times… downloaded June 27, 2012

June 22, 2012

In this Issue:

LHDs Urged to Sign Letter Calling on Congress to Address 8% Cut in Federal Spending; Deadline Extended

In January 2013, all non-defense discretionary (NDD) programs face across-the-board cuts of 8.4% through a "sequester," passed as part of the Budget Control Act last year in the agreement between Congress and the White House to raise the debt ceiling. Public health funding fall into this category of federal spending

The Coalition for Health Funding and other national coalitions representing various non-defense sectors drafted a letter urging Congress to avoid the sequester by passing a "balanced approach to deficit reduction that does not include further cuts to NDD programs." Nearly 2,000 local, state and national organizations have already signed the letter. The deadline to sign onto the letter has been extended to close of business **Friday, June 29** and NACCHO is urging local health departments to sign.

National Prevention Strategy

Measuring Progress

The Strategy includes key indicators for a) the overarching goal, b) the leading causes of death, and c) each Strategic Direction and Priority. These indicators will be used to measure progress in prevention and to plan and implement future prevention efforts. Key indicators will be reported for the overall population and by subgroups as data are available. Indicators and 10-year targets are drawn from existing measurement efforts, especially Healthy People 2020. Detailed information about the key indicators can be found in Appendix 2. In some cases, data that can help describe the health status of certain populations are limited (e.g., data on sexual orientation and gender identity, disability status). As data sources and metrics are developed or enhanced, National Prevention Strategy's key indicators and targets will be updated.

Other National Strategies

HHS Prevention Strategies

Healthy People serves as the foundation for prevention efforts across the U.S. Department of Health and Human Services (HHS). Healthy People supports HHS efforts to create a healthier Nation, including:

- Tobacco Control Strategic Action Plan
- HHS Initiative on Multiple Chronic Conditions
- Action Plan for the Prevention, Care and Treatment of Viral Hepatitis
- Healthcare-Associated Infection (HAI)
- Public Health System, Finance, and Quality Program
- HHS Action Plan to Reduce Racial and Ethnic Health Disparities
- National Prevention Strategy
- National HIV/AIDS Strategy
- National Drug Control Strategy
- Let's Move Campaign
- President's Food Safety Working Group
- Global Health Initiative
- U.S. National Vaccine Plan
- National Action Plan to Improve Health Literacy

History and Overview of Community Benefit: What Every Local Health Department Needs to Know

July 11, 2012

NACCHO Annual Conference

Julie Trocchio
Senior Director, Community Benefit and Continuing Care
Catholic Health Association

CHA
Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

Overview

- History of community benefit reporting
- Why provide community benefit
  - -- The mission imperative
  - -- The legal imperative
- Legal requirements
  - -- Community health needs assessment
  - -- Implementation strategy
- Next steps

Policy History of Community Benefit

- *Harvard Business Review*
- *New England Journal of Medicine*
- Corporate health care, Congress, and sponsors
- Health Security Act
- Senator Grassley
- Treasury, IRS and the 990 H
- Health reform

Community Benefit Categories

- Financial assistance
- Government-sponsored means tested program
- Community benefit services

Community Benefit Services – Defined by CHA

- Community health services
- Health profession
- Subsidized services
- Research
- Financial contributions
- Community building activities

Community Building Activities

- Physical improvements/housing
- Economic development
- Environmental improvements
- Other….

Mission Imperative

- Tradition of not-for-profit hospitals
- Values – concern for the poor, common good, stewardship

Legal Imperative

- Revenue Rulings
- Affordable Care Act (ACA)
- IRS Notice 2011-52
- IRS Form 990 Schedule H

ACA Requirement – Community Health Needs Assessment

- At least once every three years – 1st must be completed by end of tax year beginning after March 23, 2012
- Include input from persons who represent the broad interests of the community
- Include input from persons having public health knowledge or expertise

Affordable Care Act

ACA Requirements – Community Health Needs Assessment

- Make assessment widely available to the public
- Adopt a written implementation strategy to address identified community needs
- Failure to comply results in excise tax penalty of $50,000 per year

IRS Notice 2011-52

How a CHNA is Conducted

- May be conducted in collaboration with others – but each hospital presents own documentation
- Must take into account input from persons who represent the broad interests of the community served including those with special knowledge of or expertise in public health
- Must be made publicly available

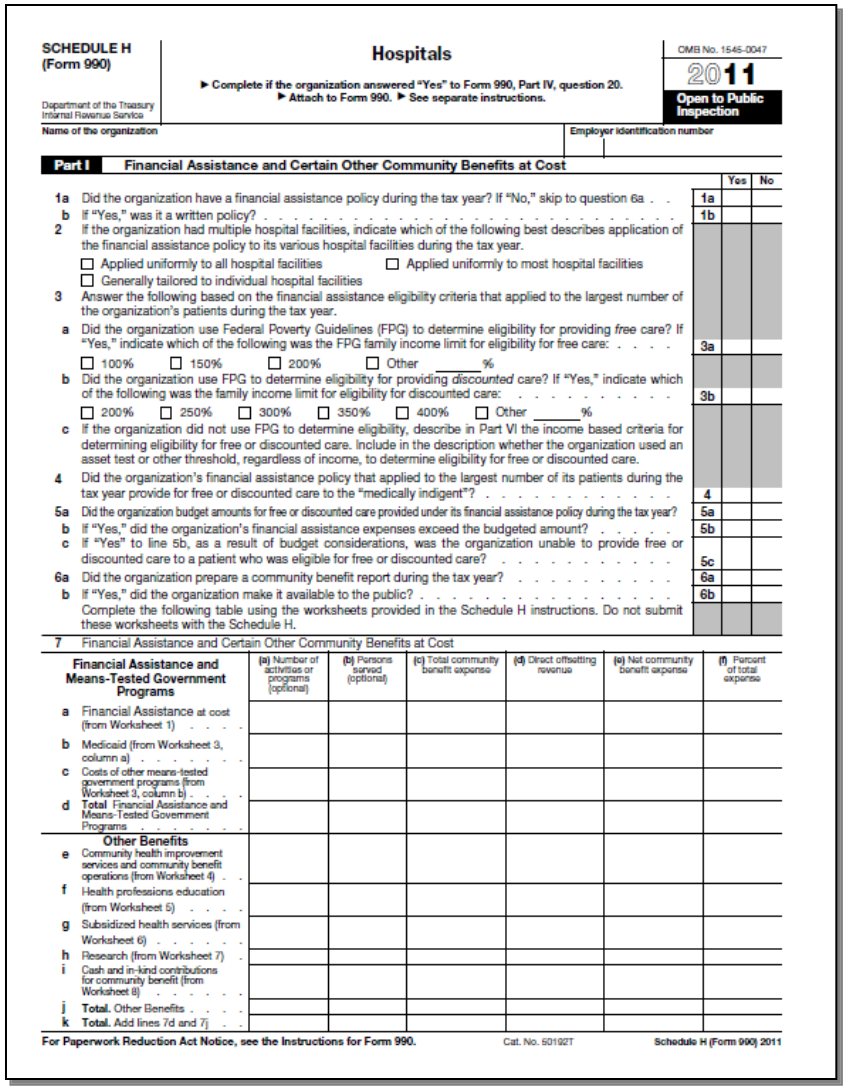
When CHNA Conducted

- During the current tax year or in either of the two immediately preceding taxable years, beginning March 23, 2012
- Considered “conducted” in the taxable year that the written assessment report is made publicly available

How Community Defined

- Generally defined by geographic location (city, county, metropolitan region)
- In some cases, defined by target populations served (e.g., children, women, aged)
- In some cases, take into account a hospital's principal function (e.g., specialty area or disease)
- May not be defined in a way that excludes certain populations served by the hospital (for example, low-income persons, and minority groups)

IRS Form 990 Schedule H



SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No. 1545-0047

2011

Open to Public Inspection

Name of the organization

Employer identification number

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a		
b	If "Yes," was it a written policy?	1b		
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a	Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☐ Other _____%	3a		
b	Did the organization use FPG to determine eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____%	3b		
c	If the organization did not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4		
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a		
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a		
b	If "Yes," did the organization make it available to the public?	6b		
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)						
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs						
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits						
k **Total.** Add lines 7d and 7j						

For Paperwork Reduction Act Notice, see the Instructions for Form 990. Cat. No. 50192T Schedule H (Form 990) 2011

Part V, B (optional for 2011)

Did assessment include?

- Definition of community
- Demographics of community
- Existing facilities and resources available to respond to needs
- How data is obtained
- Health needs of community
- Primary and chronic disease needs and other needs of
  - -- uninsured persons
  - -- low-income persons, and
  - -- minority groups
- Process for identifying and prioritizing needs
- Process for consulting with persons representing community's interest
- Information gaps

Implementation Strategy

- IRS Notice 2011-52
- IRS Form 990 Schedule H

Implementation Strategy – IRS Notice

What is an implementation strategy?

- A written plan that addresses each of the community health needs identified through a CHNA for the hospital
- Describes either:
  - -- How the hospital plans to meet the health need, or
  - -- Why the hospital does not intend to meet the health need
- Must tailor the description to the particular hospital, taking into account its specific programs, resources and priorities (for example, programs and resources the hospital intends to commit)
- Adopted by governing body

Implementation Strategy – IRS Notice

Implementation strategies can be collaborative

- Can describe any planned collaboration with governmental, non-profit, or health care organizations for meeting health needs
- Can be developed in collaboration with other hospitals, agencies (must identify who and each hospital must present its own implementation strategy)

Part V, B – (Optional for 2011)

If hospital addressed needs from CHNA, did it include?

- Adoption of an implementation strategy
- Execution of the implementation strategy
- Participation in community-wide community benefit plan
- Execution of a community-wide community benefit plan
- Inclusion of a community benefit section in operational plan
- Adoption of budget for services identified in CHNA
- Prioritization of health needs in community
- Prioritization of services the hospital will do

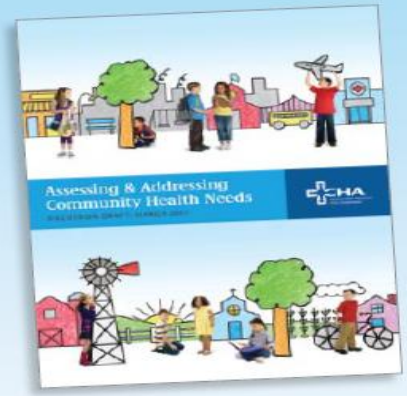
CHA Resources

CHA'S Newest Community Benefit Resource

ASSESSING & ADDRESSING COMMUNITY HEALTH NEEDS

Assessing community health needs and developing plans to address selected needs are essential to effective community benefit programs. This concept was reinforced by the Patient Protection and Affordable Care Act, enacted March 23, 2010, which contains new requirements for tax-exempt hospitals to conduct community health needs assessments and to adopt implementation strategies to meet the health needs identified through the assessments.

CHA, in collaboration with VHA Inc. and the Healthy Communities Institute, has developed this new resource to help not-for-profit health care organizations strengthen their assessment and community benefit planning processes. Using CHA's previous work, the experience of community benefit professionals and public health expertise, this resource offers practical advice on how hospitals can work with community and public health partners to assess community health needs and develop effective strategies for improving health in our communities.



CHA
Catholic Health Association of the United States

Download your electronic copy of the discussion draft today at
www.chausa.org/assessplanresources

Next Steps

- IRS proposed/final rules on financial assistance, billing, and CHNA
- IRS Form 990 Schedule H and Instructions
  - -- 2012
  - -- 2013
- CHA/VHA Conference – St. Louis
  - -- July 24-25, 2012

Kaiser Permanente's Approach to Community Health Improvement and CHNA

NACCHO Annual meeting

July 11, 2012

Jean Nudelman, Director

Kaiser Permanente

Community Benefit Programs

Northern California Region

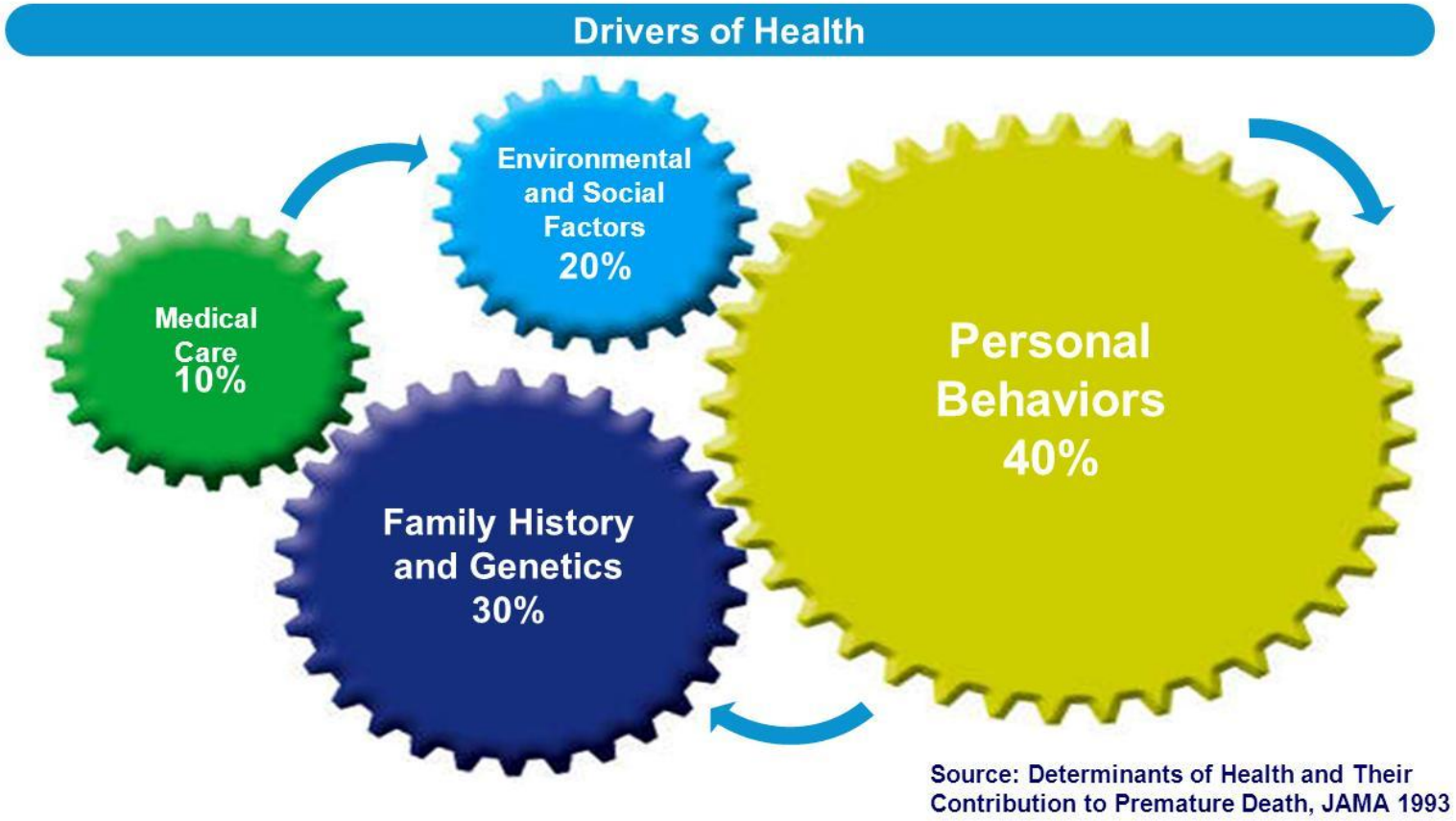
Mission and Vision

"To provide high quality, affordable health care,

and to improve the health of our members and the communities we serve"

Our CB vision is that Kaiser Permanente will play a leading role in addressing the needs of the low-income and underserved - so that all people live in **healthy**, **vibrant** communities with access to ***quality health care.***

Population Health

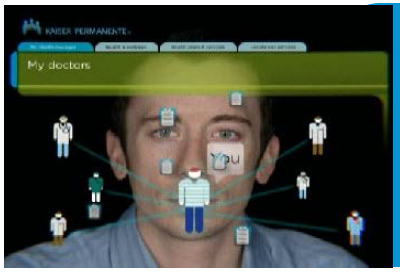


Source: Determinants of Health and Their Contribution to Premature Death, JAMA 1993

Improving the health of population

At Kaiser Permanente, we have long recognized that medical care is only one factor to improve the health of populations including our members.

INTEGRATED CARE
Reliable and effective care delivery system with a focus on prevention



ONLINE ENGAGEMENT
Online resources, health coaching, mobile apps

ENVIRONMENTAL & COMMUNITY STRATEGIES
Support healthy choices where we live, work, learn and play

KP's Community Investments

APPROACH

- Leverage Kaiser Permanente's unique assets
- Address the needs of low-income, underserved communities
- Promote prevention and population health
- Leverage external partnerships
- Include strategic grant funding

STRATEGY

- Provide care and programs
- Share the wide range of knowledge and expertise
- Invest through charitable contributions

Community Investments: Goals and Focus Areas

GOAL	FOCUS AREA	EXAMPLES
Improve the Health of the Communities We Serve	Health Access	▪ Medical Financial Assistance Program ▪ Child Health Plan ▪ Safety Net Partnerships
Reduce Health Disparities	Healthy Environments	▪ HEAL (Healthy Eating Active Living) ▪ Violence Prevention ▪ Green Initiatives
	Health Knowledge	▪ Department of Research ▪ Graduate Medical Education (Residency) ▪ Pipeline/Youth Internships

Working Through Partnerships

We partner with:

- Community Health Centers
- Public Hospitals/Health Systems
- School Based Health Centers
- Schools
- Community Based Organizations
- Public Health Departments
- Funders (California Convergence Community Clinic Funders)
- Hospitals
- Researchers
- Government Entities

COMMUNITIES PUTTING PREVENTION TO WORK

The California Endowment

LET'S MOVE!

CONVERGENCE PARTNERSHIP

Partnership for a Healthier America

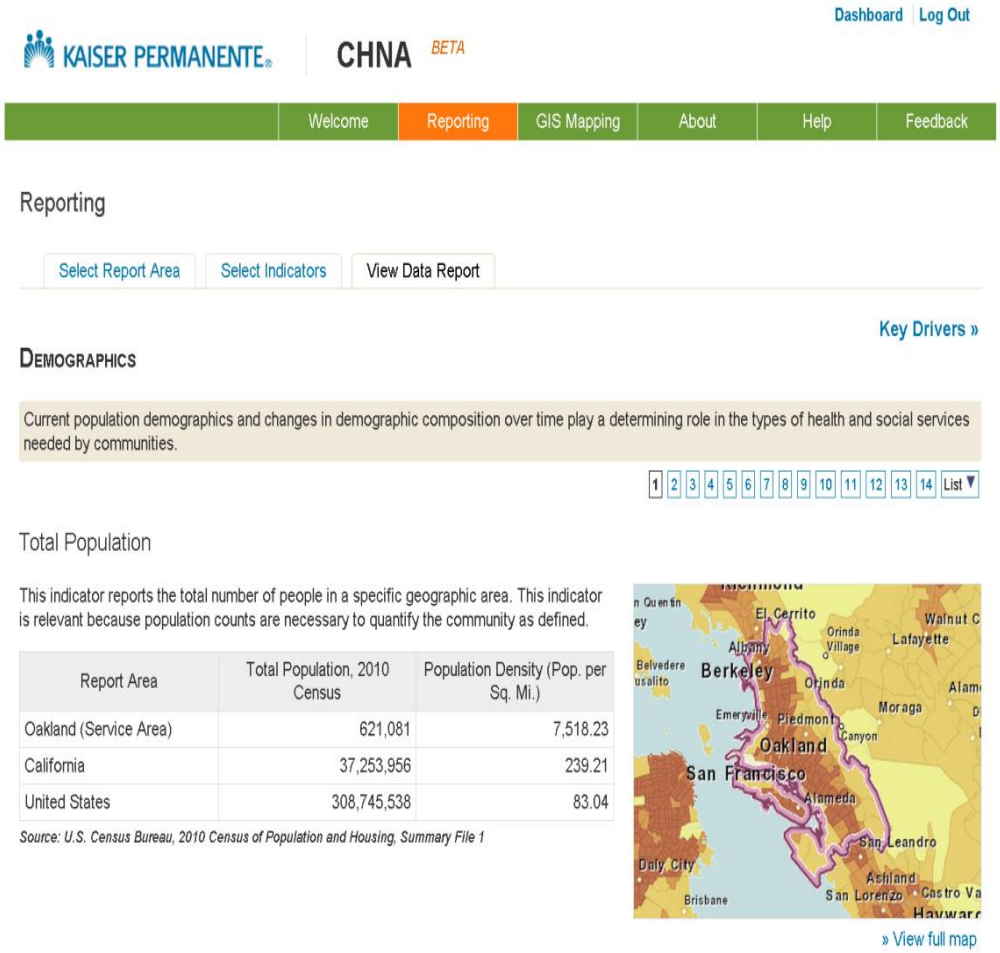
It is critical to coordinate with other funders to maximize results

Community Health Needs Assessment

ACA requires CHNA for all nonprofit hospitals

Key components of KP's CHNA strategy:

- Common indicators
- Shared data platform for analyses/interpretation
- Identification of best practices
- Community of practice



CHNA recommits us to being transparent and an accountable community asset

KP's Approach to CHNA

Builds on our assets/resources:

- Commitment to population health and community health improvement
- Long history of conducting CHNAs in CA with many community collaboratives
- Long-standing commitment to CB, and breadth of Community Benefit portfolio as well as assets in our organization
- Acknowledges our structure, a multi-hospital, integrated care system

KAISER PERMANENTE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS MAP

Data Collection & Interpretation

KP CHNA Data Platform

- Demographics
- Key Driver Data
- Health Outcomes Data
- Drivers of Health Data

→ Data Platform Report →

- Community Assets & Resources
- Other Secondary Data
- Community Input
- Public health expert input

Identification, Prioritization & Selection of Health Needs

Data Interpretation Process → Community Health Needs

Prioritization Process ↓

Prioritized Community Health Needs → Selection of Needs → CHNA Report

Implementation Strategy Development

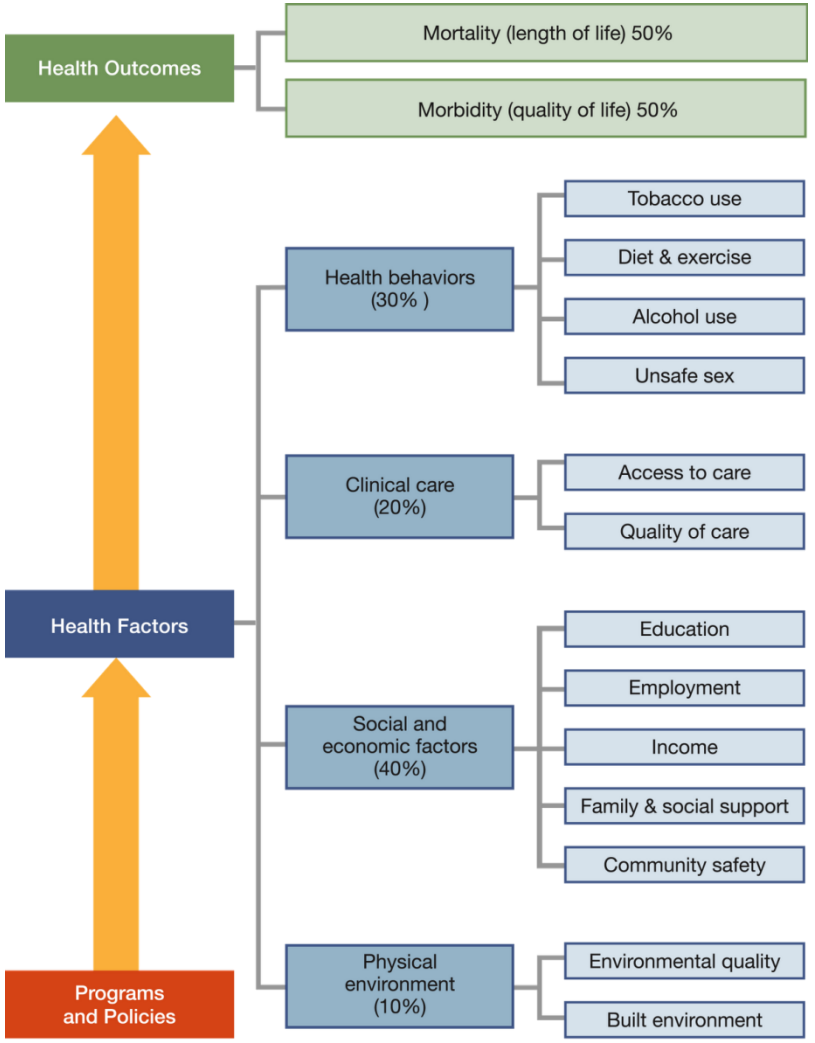
Needs that KP will address → Applying Evidence, Leveraging KP Resources → Implementation Strategy → Measures → Implementation Strategy Report

Needs that KP will not address

Health indicators

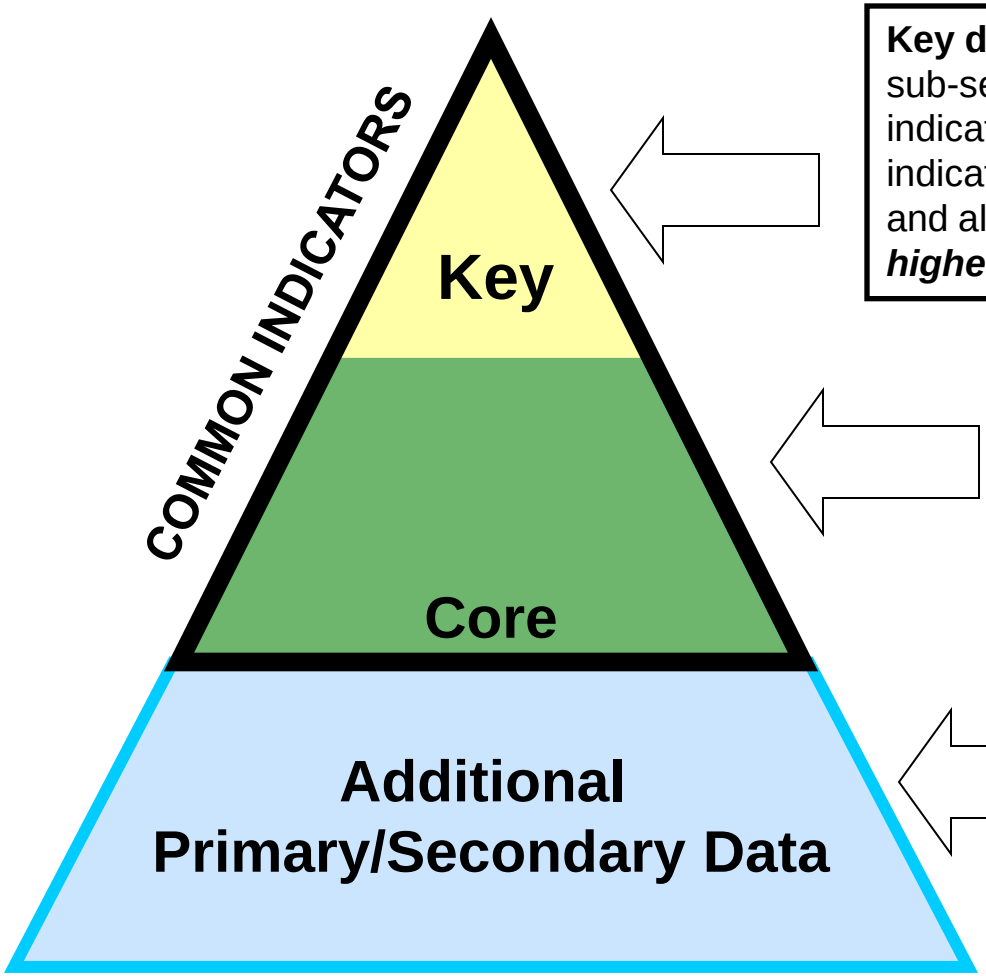
MATCH with modifications

County Health Rankings & Roadmaps
A Healthier Nation, County by County



County Health Rankings model ©2010 UWPHI

Visualizing the Layers of Data



Key drivers: all regions have a common prioritized sub-set of 3 indicators within the larger core of indicators, that highlight the most powerful indicators of population health and health needs and allow for identification of ***the places of highest concentrated need***

Core Indicators: All regions receive pre-populated set of 80-120 core indicators that represent important health issues and reflect KP's CB strategy and help identify ***the key health needs of the community***

Additional: Facilities/regions can examine additional data including secondary data available from CARES or other sources, or primary data such as local focus group data, photo voice results and state specific data sources (e.g. CHIS)

Key Driver Indicators

1. **Poverty (% under poverty level)*
   by zip code, families/individuals**

2. **HS graduation (% population over 25 w/ less than HS diploma)**

3. **Uninsured (% uninsured)**

+ All the core indicators are available on a sub-county level which allows us to pin point hot spots and retain original rationale for core set

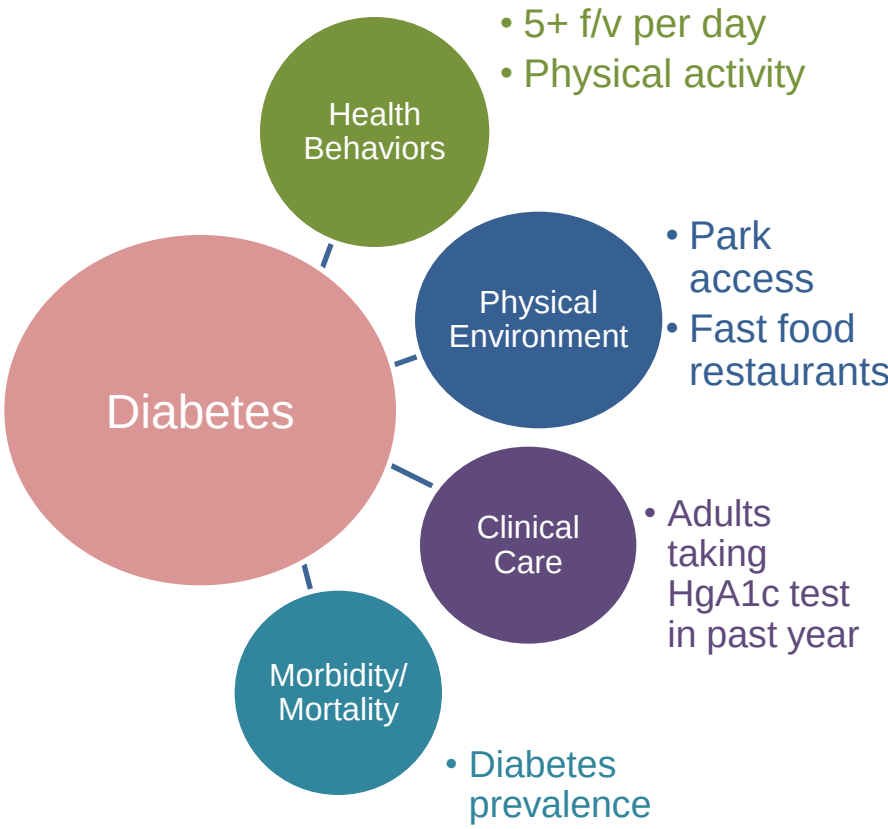
- Only includes socioeconomic indicators and no specific health indicator.

Data Indicators

Indicator by Type*

Demographics	•Total population •Race/ethnicity •Age
Social & Economic Factors	•Poverty •Educational attainment •Uninsured
Health Behaviors	•Adults currently using tobacco •Children consuming 5+ servings f/v per day •Initiating breastfeeding
Physical Environment	•Fast food restaurants •Park access •Particulate matter 2.5 above standard
Clinical Care (Access & Delivery)	•Adults with usual source of primary care •Adults 18-64 ever tested for HIV •Adults with dental visit in past year
Health Outcomes (Morbidity & Mortality)	•Children who have asthma •Adults who are overweight •Heart disease mortality

Indicator by Health Need



* List not exhaustive

Web-Based Data Platform

KAISER PERMANENTE® | CHNA BETA

Hi, kp
Sign Out

Home | Reporting | About | Feedback

Reporting

Select Report Area | Select Indicators | View Data Report

DEMOGRAPHICS

Key Drivers »

Current population demographics and changes in demographic composition over time play a determining role in the types of health and social services needed by communities.

Total Population

This indicator reports the total number of people in a specific geographic area. This indicator is relevant because population counts are necessary to quantify the community as defined.

Report Area	Total Population, 2010 Census	Population Density
Northern California (Region)	11,440,733	675.41
California	37,253,956	239.21
U.S.	308,745,538	83.04

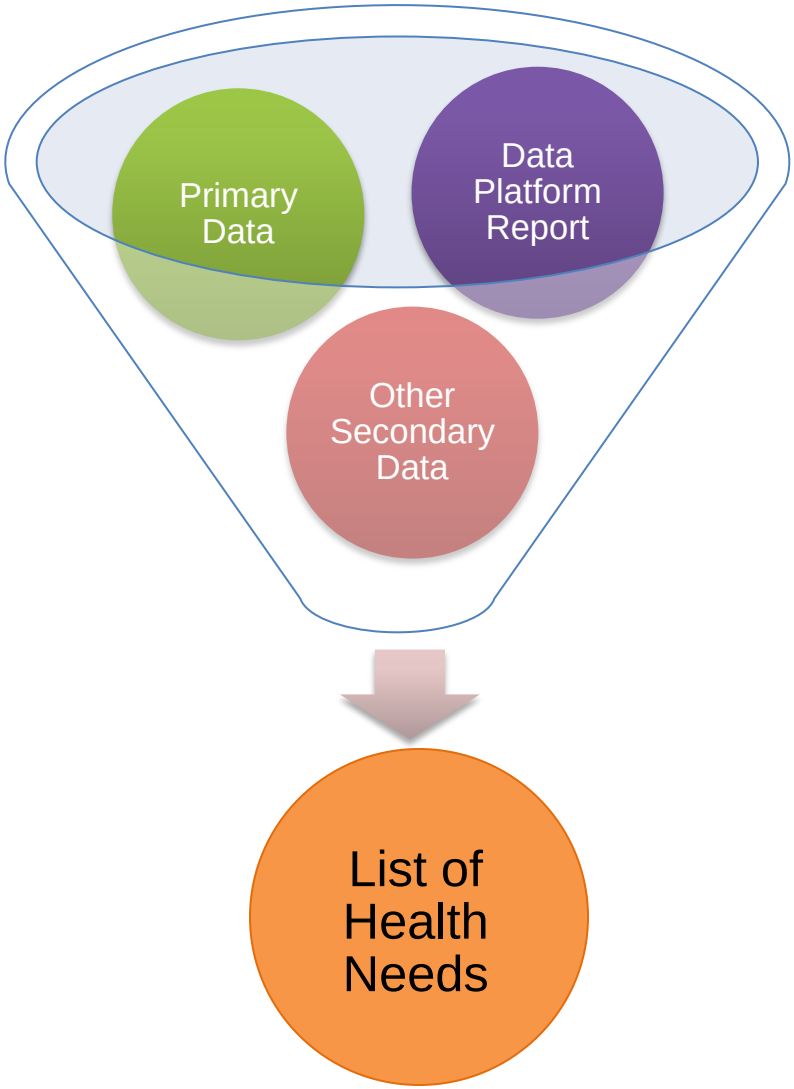
Source: U.S. Census Bureau, 2010 Census of Population and Housing, Summary File 1

» View full map

Prioritization process

- More explicit process required
- Opportunities for greater transparency, involvement with community partners
- Each facility ultimately needs to include a description of those needs that are, and are not, included in the facility's implementation strategy

Interpretation of Data & Identification of Needs



Examples of criteria:
- Definition of health need
- Over or under a benchmark

Helps us determine:
- What is a health need and what isn't

Prioritization of Health Needs

List of All Health Needs

- High Priority Needs
- Medium Priority Needs
- Low Priority Needs

Examples of criteria:

- Affecting the most people
- Probability of making an impact on issue

Helps us determine:

- How to rank the health needs from first, second, third and on for the entire list.

Selection of Health Needs

Prioritized Description of All Health Needs Identified

Needs KP Will Address

+

Needs KP Will Not Address

Examples of criteria:
- KP resources & expertise
- Not already being addressed by other community resources

Helps us determine:
- Which needs KP will select to addresses and which will not be selected and why

Challenges & Opportunities in new CHNA requirements

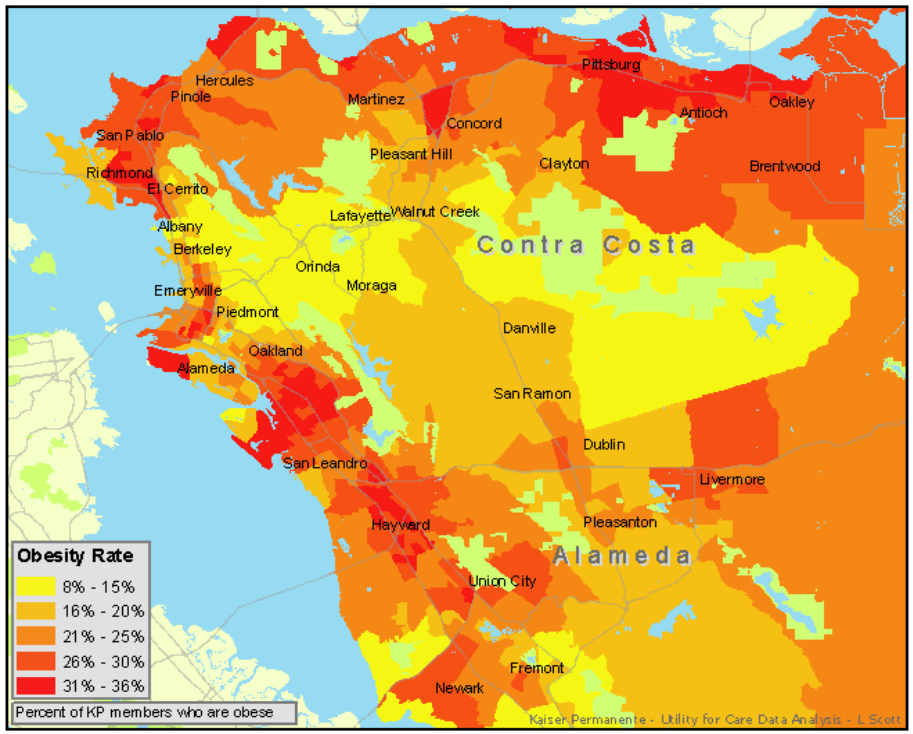
Challenges	Opportunities
• Interpreting and implementing new regulations • Data availability, granularity and timeliness • Aligning with existing processes • Identifying evidence-informed interventions	• Systematically look at need across geographic areas and across KP regions • Create and use new tools including web based systems • Working collaboratively with many partners, opportunities for alignment, collective impact

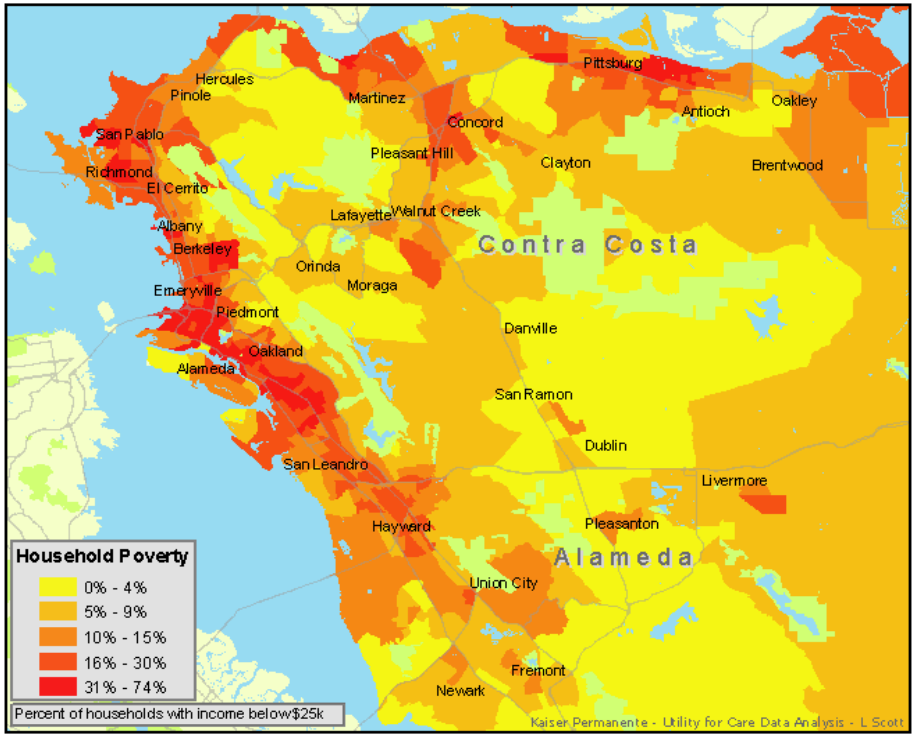
The Challenge with Data

It is not comprehensive or available in for as small an area as we'd like:

- Lack of comparability between national vs. state/county/neighborhood data
- Cost of data and data maintenance
- Need to manipulate data to be more meaningful for analyses (small area estimates, multi-year estimates, indexes, etc.)
- Sub-group breakdowns to analyze disparities

Addressing Health Disparities





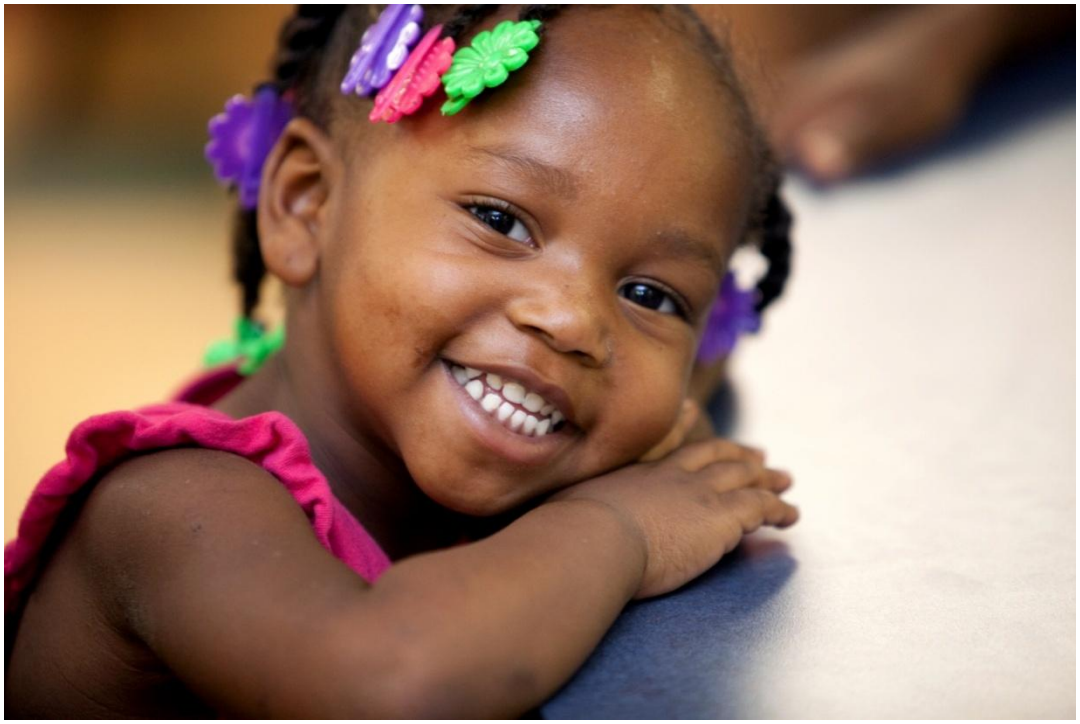
Health Disparities

- In the United States today, the health of racial and ethnic minorities, poor people, and other disadvantaged groups is worse than the health of the overall population. We believe ending these disparities is one of the most important issues we face as a nation.
- Important to highlight and assess data on a granular level to inform strategic planning around addressing issues of health disparities
- Public health departments have rich experience with creating data sets, analyzing and addressing health disparities

Opportunity to Improve the Health of Our Communities

- Better understand the needs and assets of the communities served by our facilities
- Lead to better alignment of CB investments in communities
- Increase collaboration with community leaders, local government, and other non-profit hospitals

Questions?



Jean Nudelman, Director
KP Community Benefit Programs
Northern California Region
Jean.Nudelman@kp.org

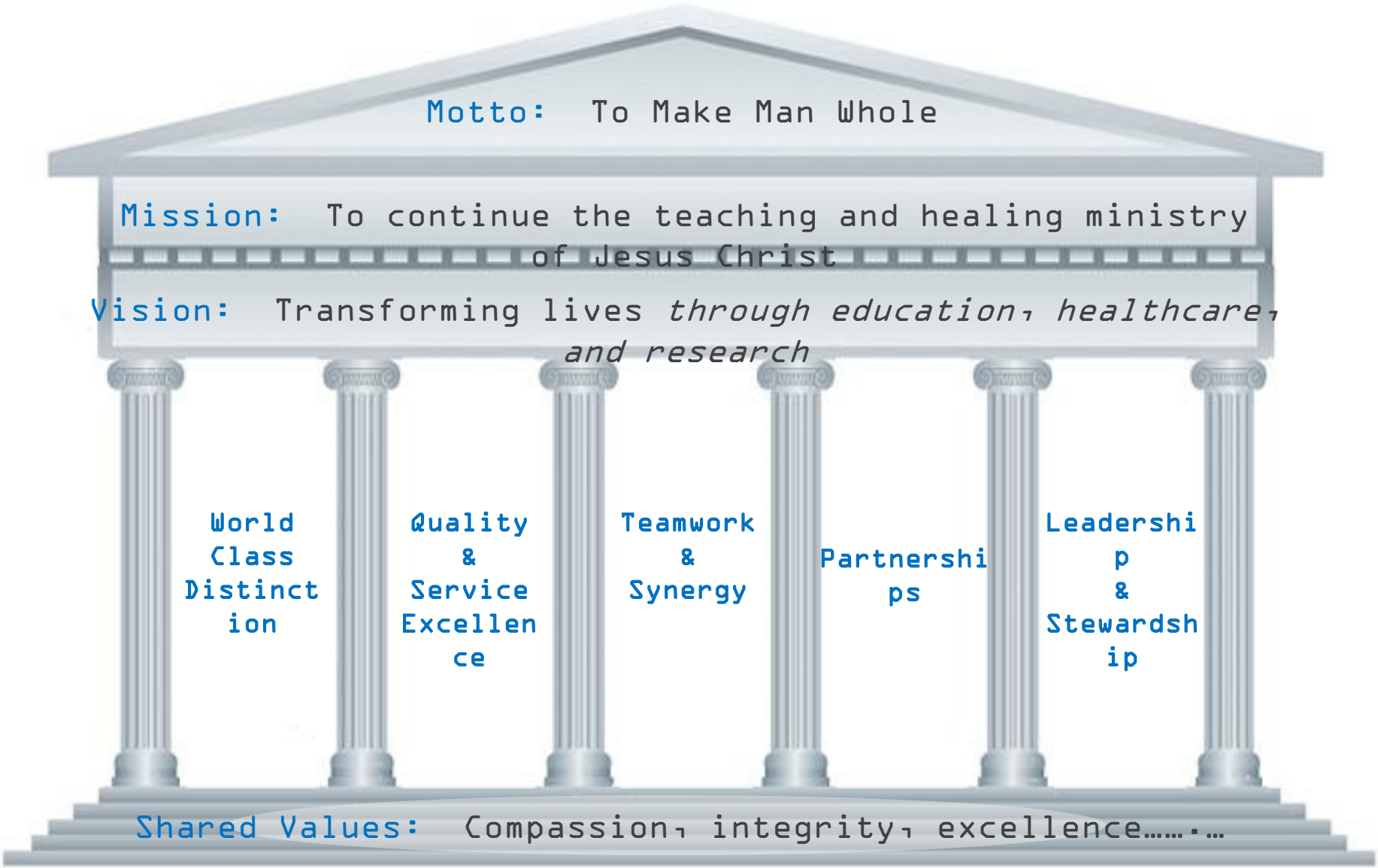
LOMA LINDA UNIVERSITY

HEALTH SYSTEM

Community Health Development

A New Day for Community Health

Dora Barilla, DrPH, MPH, CHES



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HEALTH SYSTEM

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HEALTH SYSTEM
Community Health Development

Community Health Needs Assessment

Listening to the Community

- Morbidity and Mortality Data
- Hospitalization and Emergency Department Utilization
- Social Determinants of Health
- Health Indicator Data
  - Substance Abuse
  - Injury and Violence
  - Environment
  - Nutrition and Weight Status
  - Physical Activity

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HEALTH SYSTEM
Community Health Development

Community Health Needs Assessment

Listening to the Community

- Collaboration survey within our health system
- Physician Survey
- Community Agencies
- Key informant interviews
- Focus groups

Key Partnerships

- San Bernardino County Community Benefits Collaborative
- San Bernardino County Department of Public Health Vital Signs Project

LOMA LINDA UNIVERSITY

HEALTH SYSTEM

Community Health Development

New Paradigm for Hospitals in Population Health Improvement

Current Reality	Vision
Disease Treatment	Prevention
Hospital and Physician Centered	Community Centered
Hospital & Physicians Dispensers of Information	Open Access to Information
Return on Investment	Return on Life
Charity Care/Under-reimbursed	Community Health

LOMA LINDA UNIVERSITY

HEALTH SYSTEM

Community Health Development

Shifting Trapped Equity

2010 Medical Care Services
$ 97,210,299

2010 Community Health Development
$ 2,534,926

2011 Community Health Development
$ 5,500,000

2012 Community Health

GIS and Evaluation

2010 Demographics

2,242,595 Population

643,783 Households

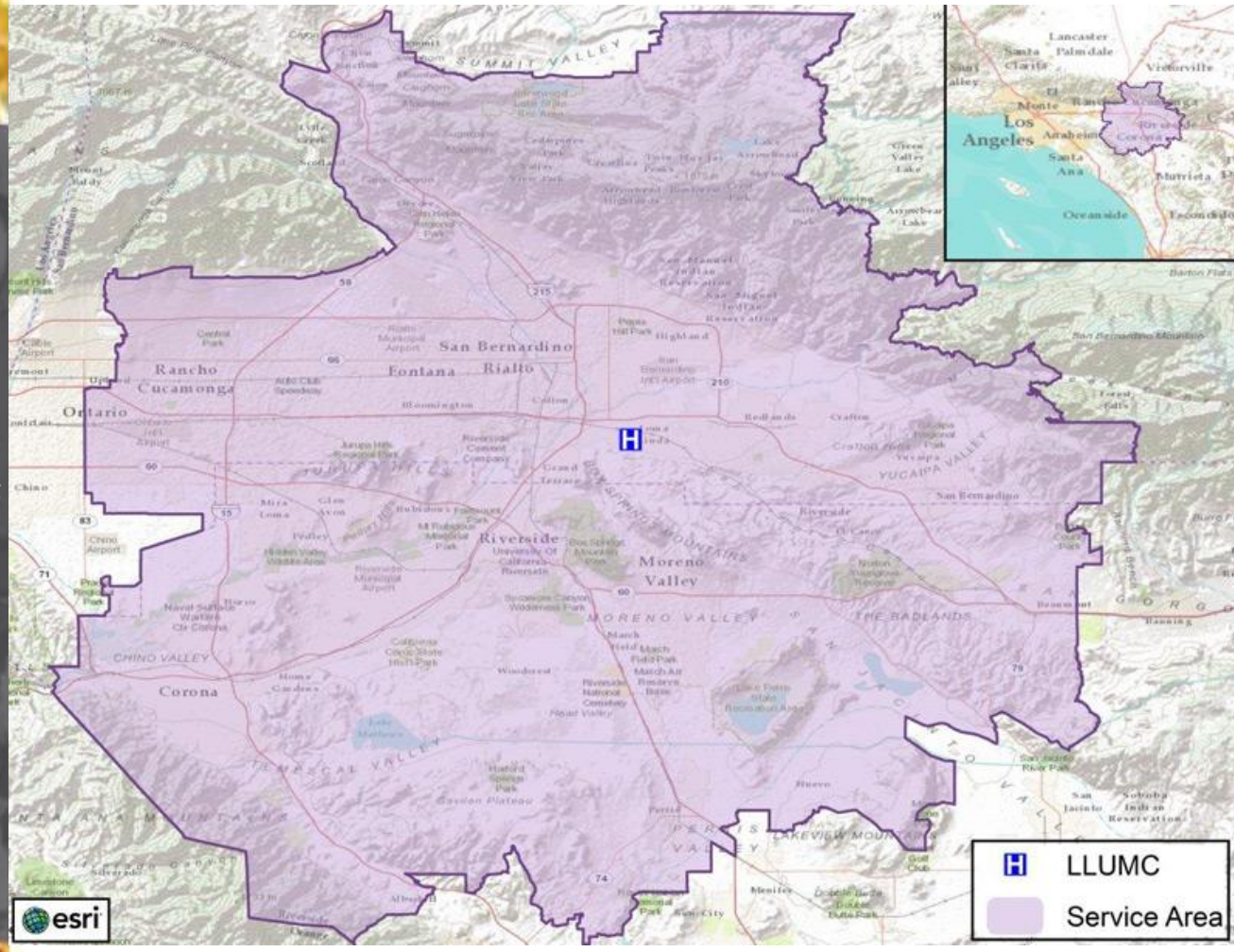
504,126 Families

30.8 Median Age

1.34% Annual Population Growth

$55,422 Median Household Income

56% 9-34 Years of Age



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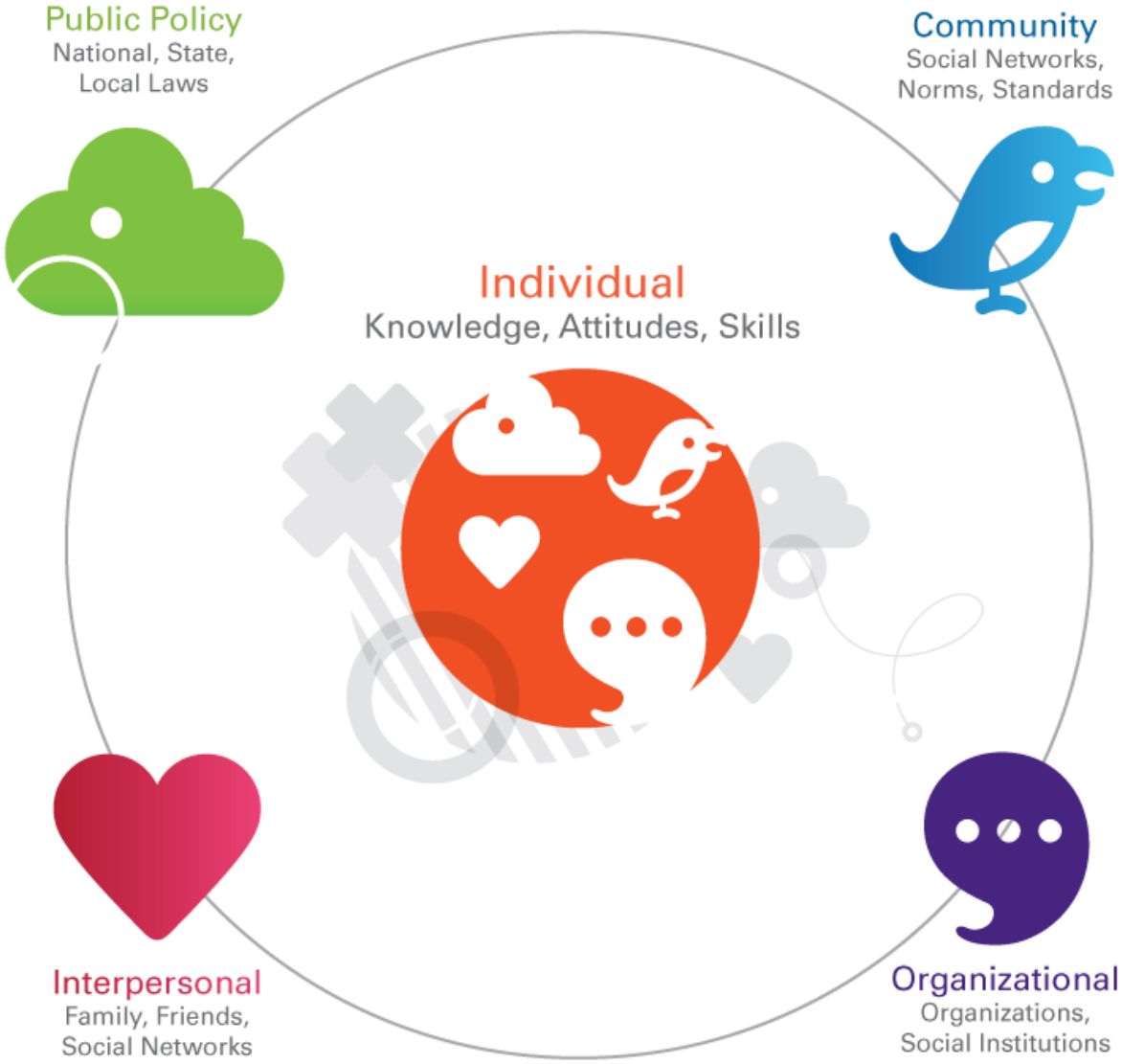
HEALTH SYSTEM

Community Health Development



FAITH & HEALTH INITIATIVE

HEALTHY COMMUNITIES INITIATIVE


Imagine...
strong,
healthy
hearts.
HEART HEALTH


Imagine...
investing
in the
future now.
CHILDREN'S HEALTH
AND RESILIENCY


Imagine...
removing the stigma from mental illness.
MENTAL HEALTH

LOMA LINDA UNIVERSITY

HEALTH SYSTEM

Community Health Development

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Partnering with your local non-profit hospital

Jill-Marie Steeley
Director of Health & Human Services
Gallatin City-County Health Department

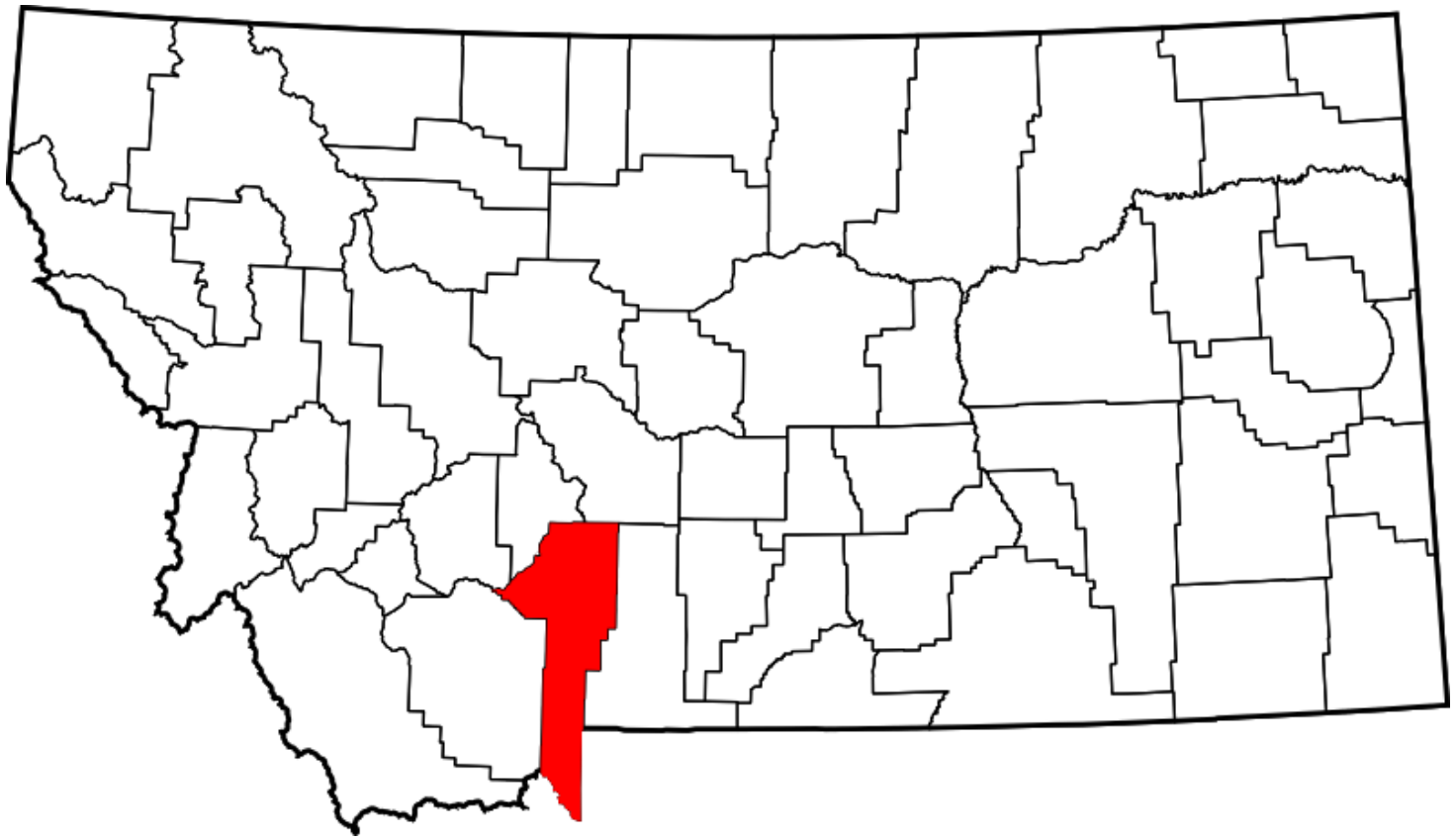
Donna Cruz-Huffmaster
Planning & Business Development Manager
Bozeman Deaconess Health Services

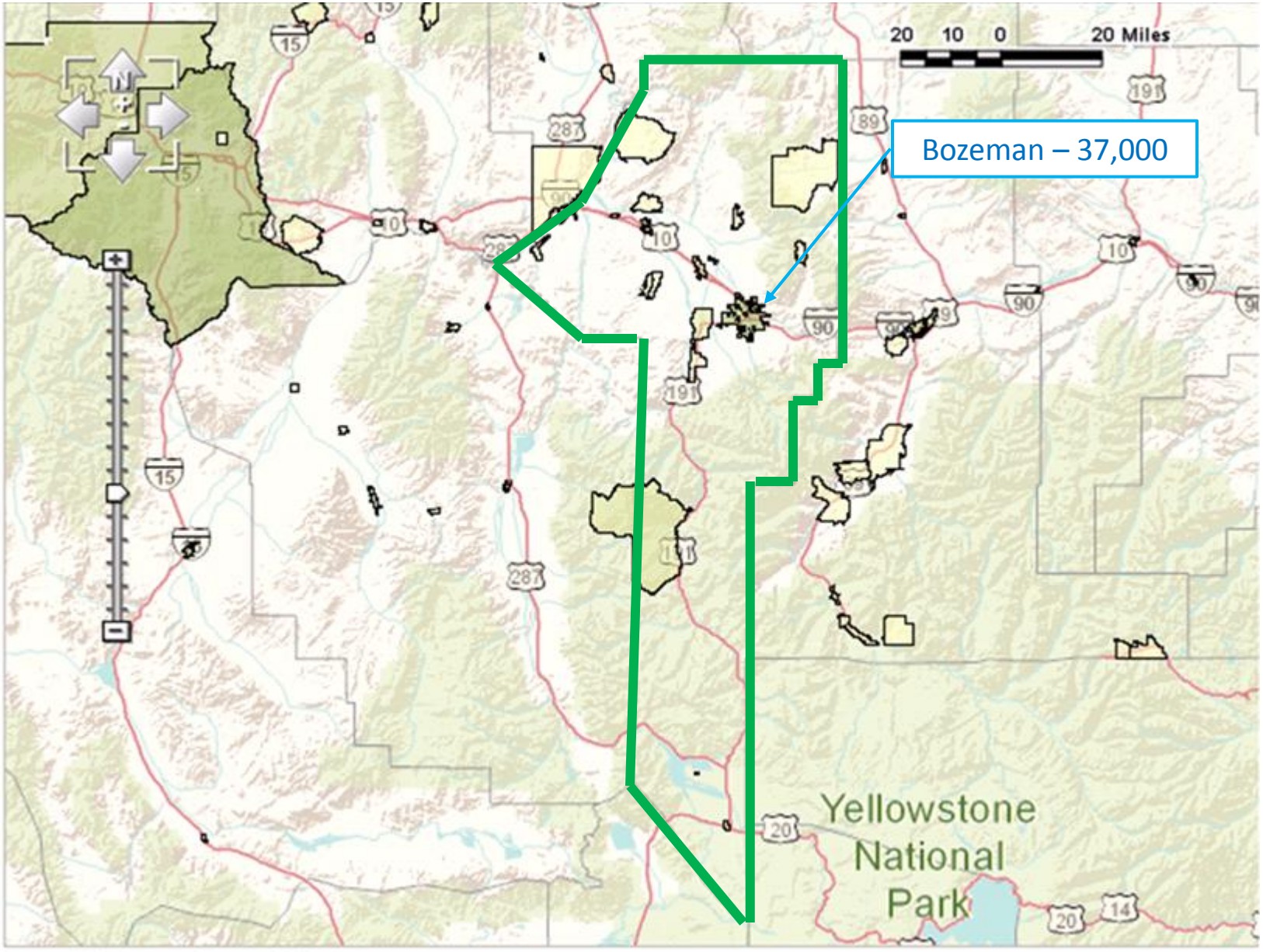
Overview

- History of deciding to partner with a hospital
- Reaching out and engaging the hospital
- What has made the partnership successful
- Challenges, and what has been learned along the way and plans for the future
- What is the value of partnering
- How can community benefit work to improve public health outcomes

Gallatin County

Population: 90,000 Census 2010




20 10 0 20 Miles
Bozeman – 37,000
Yellowstone National Park

Existing Collaboration

- Maternal child referral- Labor and Delivery
- Public Health Emergency Preparedness
- Unified Health Command- emergency response
- Immunization campaign- market research, marketing (www.immunizeMT.org)
- Community Care Connect – mobile outreach


COMMUNITY
CARE CONNECT
HEALTH NUTRITION EDUCATION ASSISTANCE


COMMUNITY
CARE CONNECT
HEALTH NUTRITION EDUCATION ASSISTANCE

Reaching out to the hospital

- Good Timing
  - Hospital was in the process of planning their next CHNA
- Contacted through the Business Development Office
- Shift in assessment from access to behavior
- Collaboratively chose the MAPP framework for the assessment

Why is it a successful partnership?

- We already had existing partnerships, so those relationships already existed
- Our priorities match – we both needed to complete a community health needs assessment
- Staff from both agencies are in constant communication – regular meetings, email exchanges, doodle polls, etc.
- Sharing of information

What challenges have we faced?

- Both agencies have boards and upper level administration who need to agree on the decisions made on the ground
- Different areas of focus:
  - Health Dept.: Behaviors, Attitudes, Population-based health as opposed to individual-based health
  - Hospital: Access to care, Disease/Conditions, Treatments, *but now moving to population health*

What have we learned?

- We are more cognizant of the hospital's community benefit program and we realize we can provide feedback as to how those funds are best utilized
- It's beneficial to all to work as a collaborative

What is the value of partnering?

- Share the cost, resources
- Maximize resources
- Brings more credibility in the community
- Brings more stakeholders to the table
- Able to extend population/demographic reach

How can Community Benefit work to improve public health outcomes?

- By being aligned with the needs/gaps identified in the assessment
- The more players you have around the table the more buy-in you'll get from the players and the community

Please go to the table of your choice to discuss the following questions:

Table 1

- What are the top factors that have led to successful local health department (LHD) and non-profit hospital community health assessment collaboration? What are some important “don’ts”?

Table 2

- What do your hospital partners value about your LHD when working on community health assessments (or other activities)? What does your LHD value about your hospital partners when working on community health assessments (or other activities)?

Table 3

- How can non-profit hospitals and other local stakeholders work to improve public health outcomes? What are opportunities and challenges of making meaningful population health changes? What are opportunities and challenges of doing this in a collaborative manner?

NACCHO
National Association of County & City Health Officials

Public Health
Prevent. Promote. Protect.