Community Health Assessment and Community Benefit: An Opportunity for Collaborations

Louise A. Kent, MBA, ASQ CQIA
Northern Kentucky Health Department
July 11, 2012
• 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

<table>
<thead>
<tr>
<th>Participation</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Yes, Within the Last Three Years</td>
<td>43%</td>
</tr>
<tr>
<td>Yes, More Than Three But Less Than Five Years Ago</td>
<td>16%</td>
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<tr>
<td>Yes, Five or More Years Ago</td>
<td>15%</td>
</tr>
<tr>
<td>No, But Plan to in the Next Year</td>
<td>17%</td>
</tr>
<tr>
<td>No</td>
<td>9%</td>
</tr>
</tbody>
</table>

Data Source: 2010 National Profile of Local Health Departments
Voluntary Accreditation Preparation

- [http://www.phaboard.org/](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.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Purpose</th>
<th>Significance</th>
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</thead>
<tbody>
<tr>
<td>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</td>
<td>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.</td>
<td>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.</td>
</tr>
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</table>

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.

<table>
<thead>
<tr>
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<th>Purpose</th>
<th>Significance</th>
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<tbody>
<tr>
<td>5.2.1 L</td>
<td>The purpose of this measure is to assess the local health department's community health improvement process and the participation of stakeholders.</td>
<td>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.</td>
</tr>
</tbody>
</table>

1. Completed community health improvement planning process that included:

   - 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 (APEXPH), 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
FY2013 Funding Update
EPA Mercury and Air Toxic Standards Under Attack; Senate Defends Clean Air Act Rules
EPA Releases Updated Standards for Particulate Matter
Senate Approves Farm Bill; Victory for Nutrition and Public Health
Negotiators Struggle to Reach Agreement on Transportation Bill Before June 30 Deadline
Health Reform Implementation
HHS Releases Health Equity Index
NACCHO Submits Comments on Modified Risk Tobacco Products
CBO Releases Report on Fiscal Impact of Cigarette Tax Increase
HHS Creates Three New Countermeasure Development Centers

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.
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
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
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
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)
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
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 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’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 experiences 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.

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

Drivers of Health

- Personal Behaviors: 40%
- Family History and Genetics: 30%
- Environmental and Social Factors: 20%
- Medical Care: 10%

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
**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**

- Improve the Health of the Communities We Serve
- Reduce Health Disparities

**FOCUS AREA**

- Health Access
- Healthy Environments
- Health Knowledge

**EXAMPLES**

- **Health Access**
  - Medical Financial Assistance Program
  - Child Health Plan
  - Safety Net Partnerships
  - HEAL (Healthy Eating Active Living)
  - Violence Prevention
  - Green Initiatives

- **Healthy Environments**
  - Department of Research
  - Graduate Medical Education (Residency)
  - Pipeline/Youth Internships
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

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
Health indicators

MATCH with modifications

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

Health Outcomes
- Mortality (length of life) 50%
- Morbidity (quality of life) 50%

Health Factors
- Health behaviors (30%)
  - Tobacco use
  - Diet & exercise
  - Alcohol use
  - Unsafe sex
- Clinical care (20%)
  - Access to care
  - Quality of care
- Social and economic factors (40%)
  - Education
  - Employment
  - Income
  - Family & social support
  - Community safety
- Physical environment (10%)
  - Environmental quality
  - Built environment

Programs and Policies

County Health Rankings model ©2010 UWPHI
**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 pinpoint 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**

- Health Behaviors
  - 5+ f/v per day
  - Physical activity

- Physical Environment
  - Park access
  - Fast food restaurants

- Clinical Care
  - Adults taking HgA1c test in past year

- Morbidity/Mortality
  - Diabetes prevalence

* List not exhaustive
Web-Based Data Platform

Reporting

Select Report Area  Select Indicators  View Data Report

Demographics

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.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population, 2010 Census</th>
<th>Population Density</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern California (Region)</td>
<td>11,440,733</td>
<td>675.41</td>
</tr>
<tr>
<td>California</td>
<td>37,253,956</td>
<td>239.21</td>
</tr>
<tr>
<td>U.S.</td>
<td>308,745,538</td>
<td>83.04</td>
</tr>
</tbody>
</table>

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

Key Drivers

» 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

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

Needs KP Will Not Address
### Challenges & Opportunities in new CHNA requirements

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

A New Day for Community Health
Dora Barilla, DrPH, MPH, CHES
Motto: To Make Man Whole

Mission: To continue the teaching and healing ministry of Jesus Christ

Vision: Transforming lives through education, healthcare, and research

World Class Distinction
Quality & Service Excellence
Teamwork & Synergy
Partnerships
Leadership & Stewardship

Shared Values: Compassion, integrity, excellence
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
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
New Paradigm for Hospitals in Population Health Improvement

Current Reality                  Vision

Disease Treatment                Prevention
Hospital and Physician Centered  Community Centered
Hospital & Physicians            Open Access to Information
Dispensers of Information       Return on Life
Return on Investment             Charity
Charity Care/Under-reimbursed    Community Health
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 Development
2010 Demographics

- Population: 2,242,595
- Households: 643,783
- Families: 504,126
- Median Age: 30.8
- Annual Population Growth: 1.34%
- Median Household Income: $55,422
- 56% 9-34 Years of Age
FAITH & HEALTH INITIATIVE
Imagine... strong, healthy hearts.
Imagine... investing in the future now.
Imagine...
removing the stigma from mental illness.

MENTAL HEALTH
Imagine...

LOMA LINDA UNIVERSITY
HEALTH SYSTEM
Community Health Development

Dora Barilla, DrPH, MPH, CHES
dbarilla@llu.edu
(909) 558-3842
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
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
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?