Alignment and Accountability in Community Health Improvement:

The Development and Piloting of a Regional Data Sharing System

NNPHI 2014 Conference
"Cacophony to Symphony: Creating Harmony in Health Priorities"

Public Health Institute
May 21, 2014

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Schedule H and Transparency

- There **will be comparative analyses** conducted at national, state, MSA, county, municipality, and congressional districts. Examples:

  - Language in charity care policies, and budget levels established

  - Billing and collection practices (e.g., eligibility criteria, thresholds)

  - How community is **defined in geographic terms** and includes proximal areas where there are **health disparities**.

  - How solicit and **use input** from diverse community stakeholders.

  - **Connection** between **priorities and program areas of focus**.

  - Explanation of why a hospital **isn't** addressing selected health needs.

Impetus for Project

- **Evidence of increased collaboration, but many hospitals**
  - Driven by institutional imperatives
  - Limited by competitive approach and dynamics
- **Community stakeholders unclear on how to engage**
  - Skeptical of assessments based upon experience to date
  - View hospitals as funder; less informed about benefits of partnership
- **Regulatory/public reporting environments moving towards increased transparency**
  - Increased availability of data/information and mechanisms for dissemination
  - Locus of oversight, engagement most feasible at the local/regional level
- **Lack of alignment represents missed opportunity**
  - Increase focus where disparities concentrated
  - Build critical mass to produce measurable outcomes

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Focus of CHIDSS Development

- **How**
  - Community is defined
  - Community stakeholders are engaged
  - Priorities are set
  - Implementation strategies are designed

- **Select specific geographic regions to allow for comparative analysis**

- **Sources of data are public reports from**
  - Hospitals
  - Public health agencies
  - United Ways
  - Community Action Agencies

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Defining Community

- IRS encourages hospitals use of **service area** to define community

- **Service areas based primarily on voluntary selection** and driven by concentration of commercially insured patients
  - May be inconsistency between defined communities for community benefit purposes and geo concentrations of health disparities
  - May also be geo concentrations of health disparities in proximal areas that are different jurisdictions

- Lack of knowledge, **historical insular tendencies** contribute to view that geo concentrations of disparities are not concerns of hospitals

- **Hospitals with limited resources** (e.g., CAH) conduct independent CHNAs

- Are **LPHAs with limited resources** conducting single county CHAs and HIPs when many health concerns and resources transcend jurisdictions.

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Community Engagement

- IRS guidance to hospitals limited to call to "consider input" from community stakeholders in CHNA process.

    - No call for information on how community input informed CHNA process

    - No call for community engagement in priority setting

    - No call for community engagement in planning or implementation processes

- Call for input from "people experiencing health disparities," "racial minorities," and "medically underserved"

Priority Setting and Implementation

- Poorly designed and implemented priority setting processes
  - Assessment of criteria; whether is level of specificity, objectivity, issues outside of institutional concerns
  - Content focus broad and focused on access to clinical services

- Disconnect between priorities and focus of programs
  - Framing is broad, allowing for perpetuation of existing programs

- Lack of focus in in geo concentrations with health disparities
  - Whether interventions are targeted for populations or communities with disparities

- Lack of measurable objectives
  - Documentation of different forms of metrics

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Compliance and Transformation

Compliance

Transformation

Shared Ownership

Co-finance consultant to conduct CHNA
Hold meetings to discuss design
Return to hospital to set priorities

Ongoing stakeholder engagement to build
common vision and shared commitments
Set shared priorities & take coordinated action

Diverse Community Engagement

Solicit input through surveys, focus groups, town halls
on health care needs – no action required
Meet with local or state PH officials

Engage diverse community stakeholders as
ongoing partners with shared accountability
Identify shared priorities to improve community health

Broad Definition of Community

Define community as hospital service area
Identify underserved pops w/in service area
Design programs at service area level

ID **concentrations of health inequities** w/in larger
region that includes hospital service area
Select geo focus where needs are greatest

Maximum Transparency

Post CHNA report on hospital website
Attach Implementation Strategy (IS) to Schedule H
submittal or post on website

Post CHNA & shared priorities in multiple settings
Develop and post IS in multiple settings with **defined
roles for diverse community stakeholders**

Compliance and Transformation, cont'd.

Compliance   Transformation

Innovative & Evidence-Informed Investments

Describe how hospital will address priority unmet needs

⟷

Survey best practices to ID strategies with **evidence** of effectiveness or that offer considerable promise
Establish **shared metrics** that will document ROI at multiple levels

Incorporate Continuous Improvement

⟷

Establish indicators of progress (e.g., systems reforms)that validate progress towards outcomes
Establish monitoring strategy that **integrates adjustments based upon emerging findings**

Pooling and Sharing of Data

⟷

Sharing of utilization data across hospitals, PH, CHCs to assess total cost of care
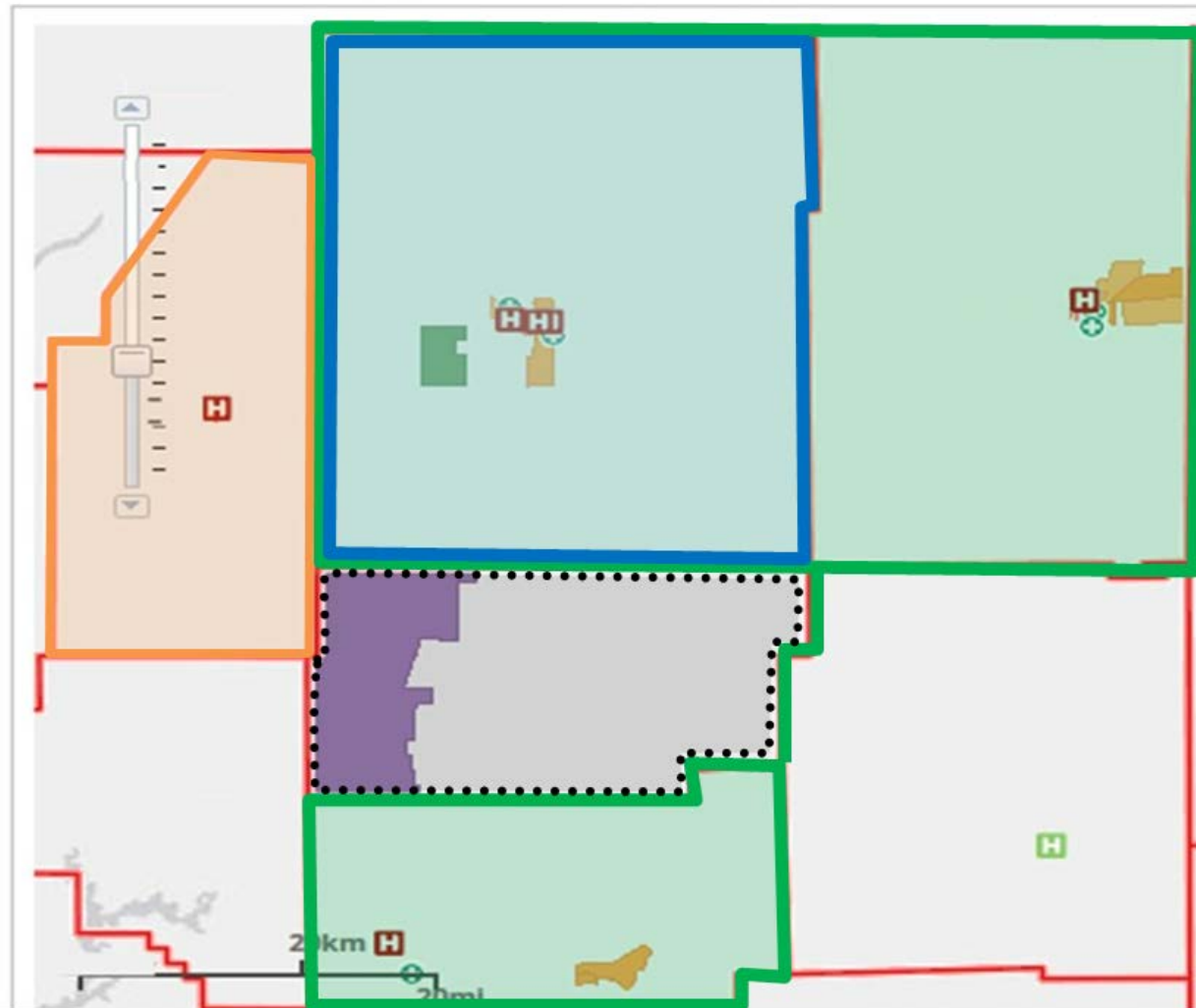Proactive determination of ROI at institutional and community level

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Service Area Exclusion of Geo Areas with Concentrated Poverty
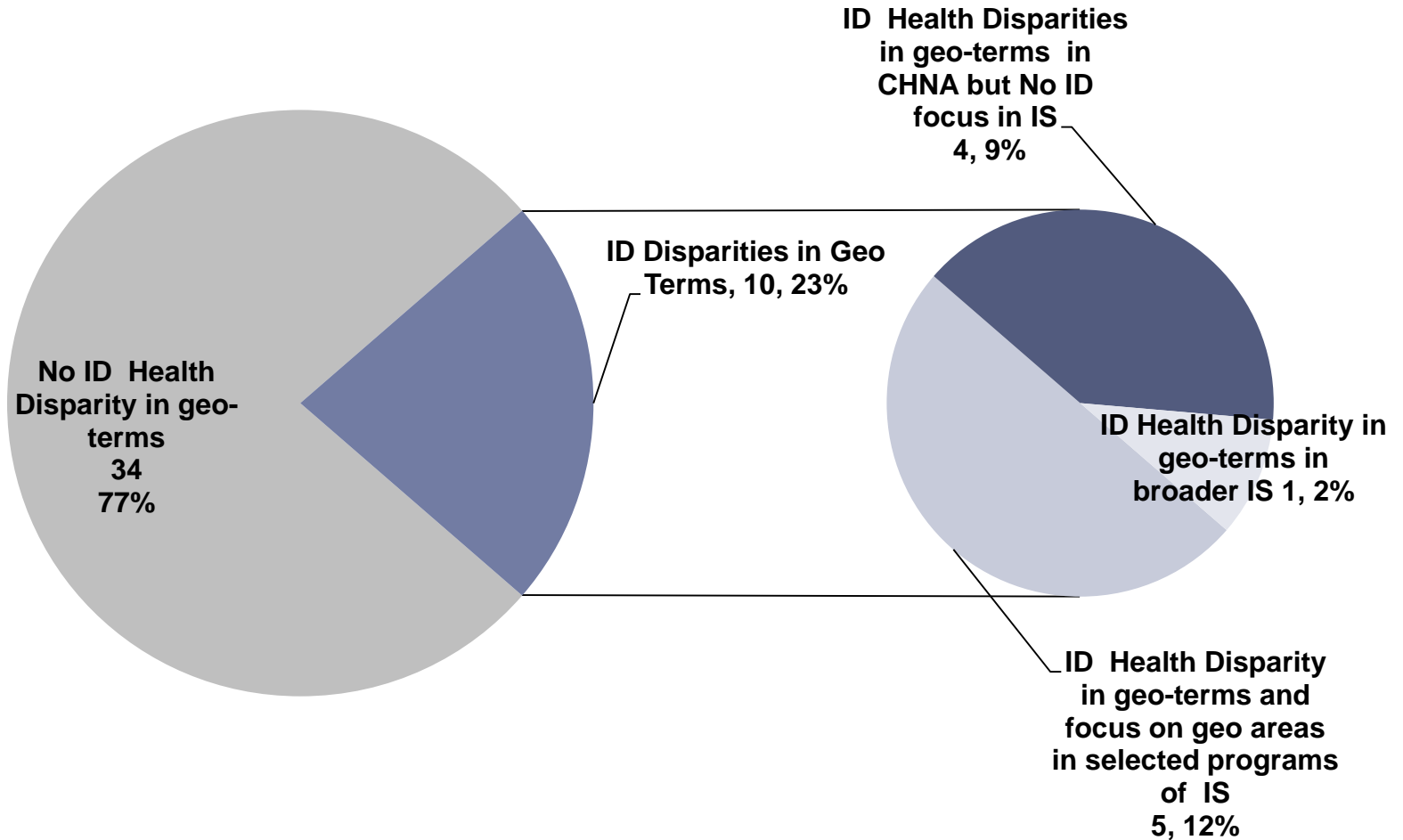

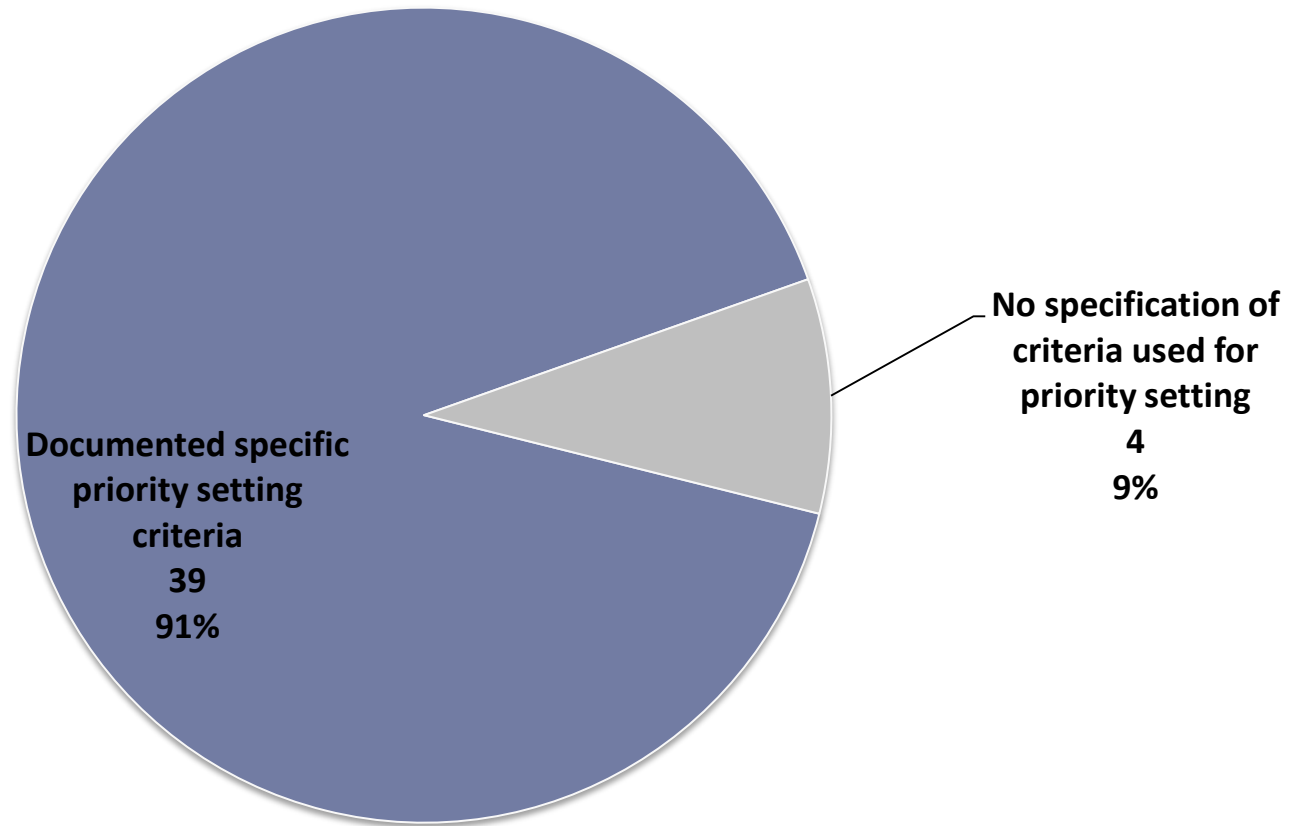Vulnerable Populations Footprint
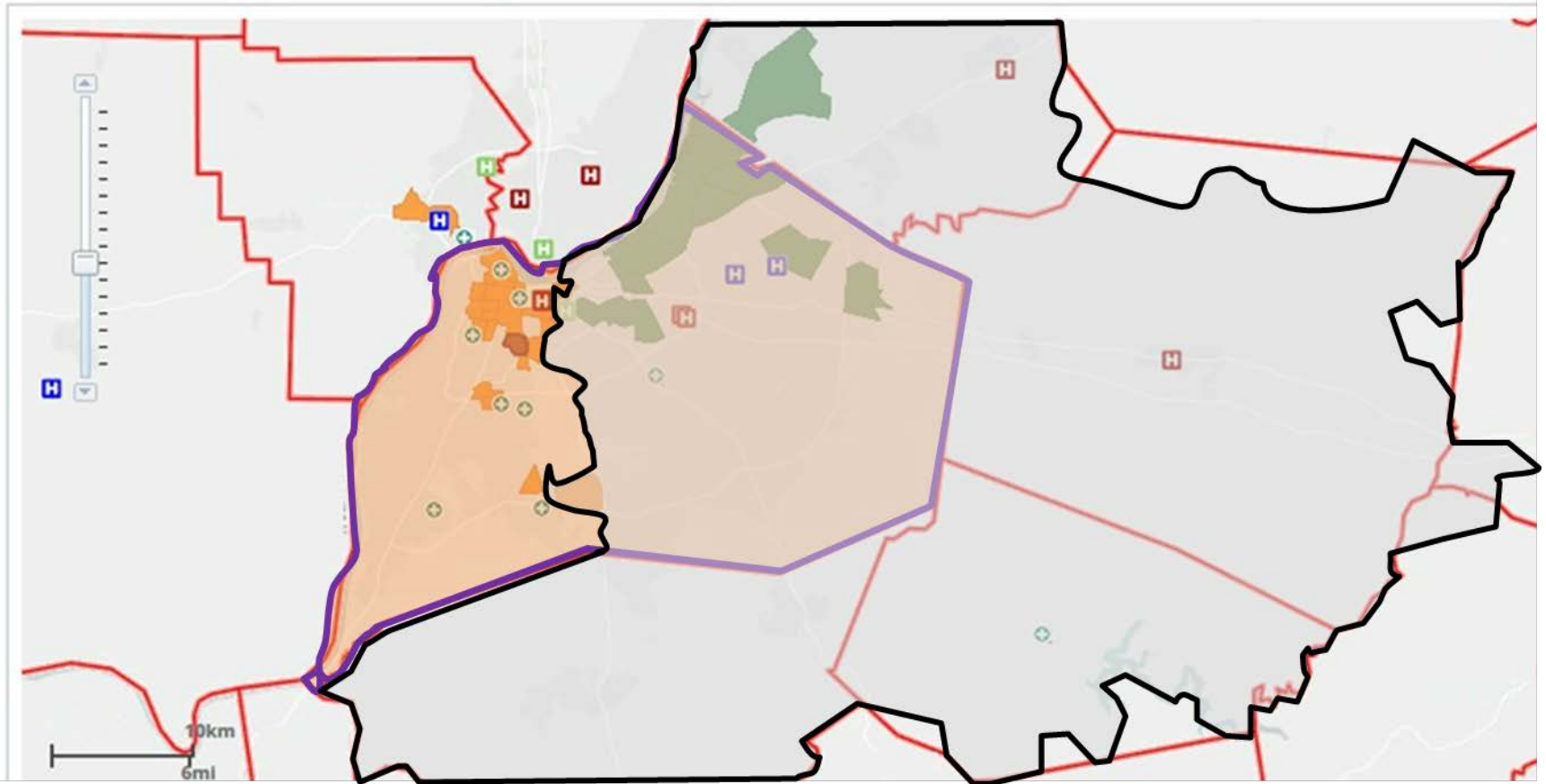
Orphan County in Identified Community

Vulnerable Populations Footprint

ID Disparities in Geo Terms and IS Focus

ID Health Disparities in geo-terms in CHNA but No ID focus in IS
4, 9%

ID Disparities in Geo Terms, 10, 23%

No ID Health Disparity in geo-terms
34
77%

ID Health Disparity in geo-terms in broader IS 1, 2%

ID Health Disparity in geo-terms and focus on geo areas in selected programs of IS
5, 12%

Documentation of Priority Setting Criteria

Documented specific priority setting criteria
39
91%

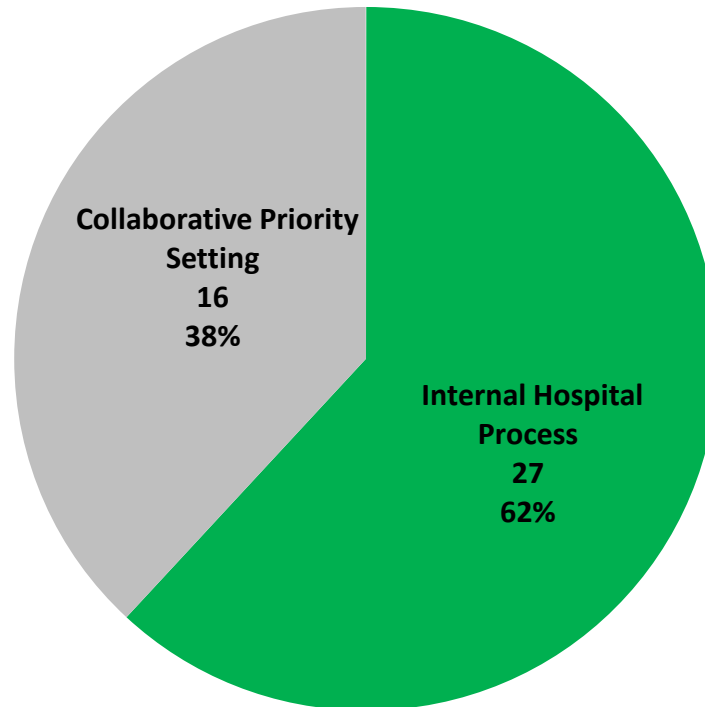No specification of criteria used for priority setting
4
9%

Provide description of process/criteria used in prioritizing health needs (2011-52 sec.3.03)

Priority Setting

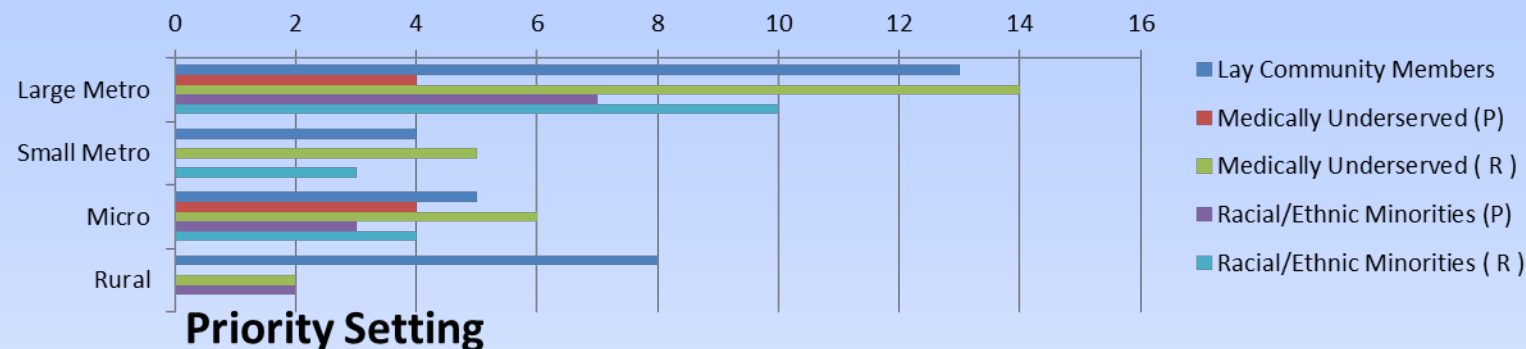

Collaborative and Internal Hospital Priority Setting

Collaborative Priority Setting
16
38%

Internal Hospital Process
27
62%

Priority Setting Criteria
Sufficient Specificity to Inform Decision Making

Criteria lacks
specificity
18
45%

Criteria with
sufficient
specificity
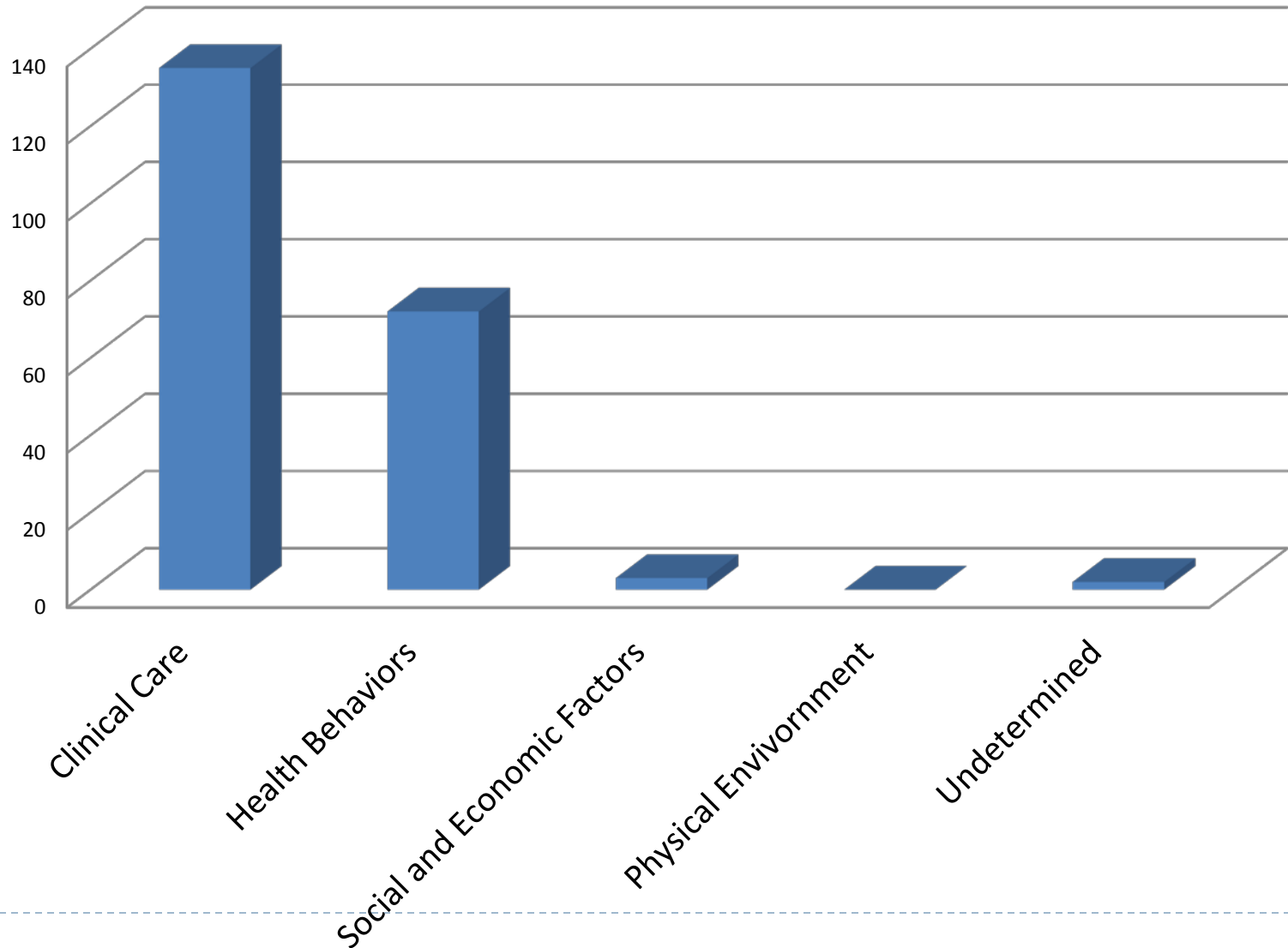22
55%

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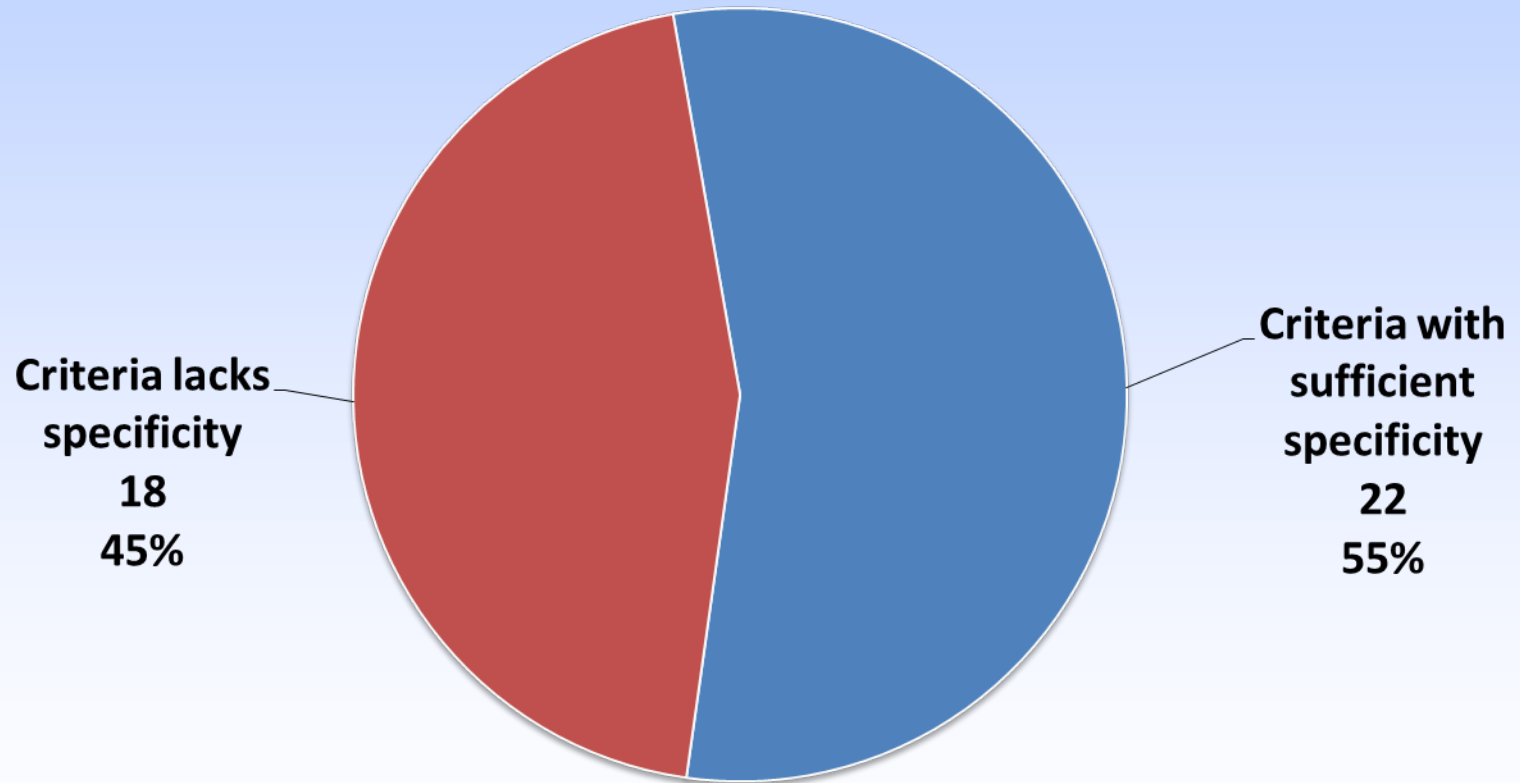
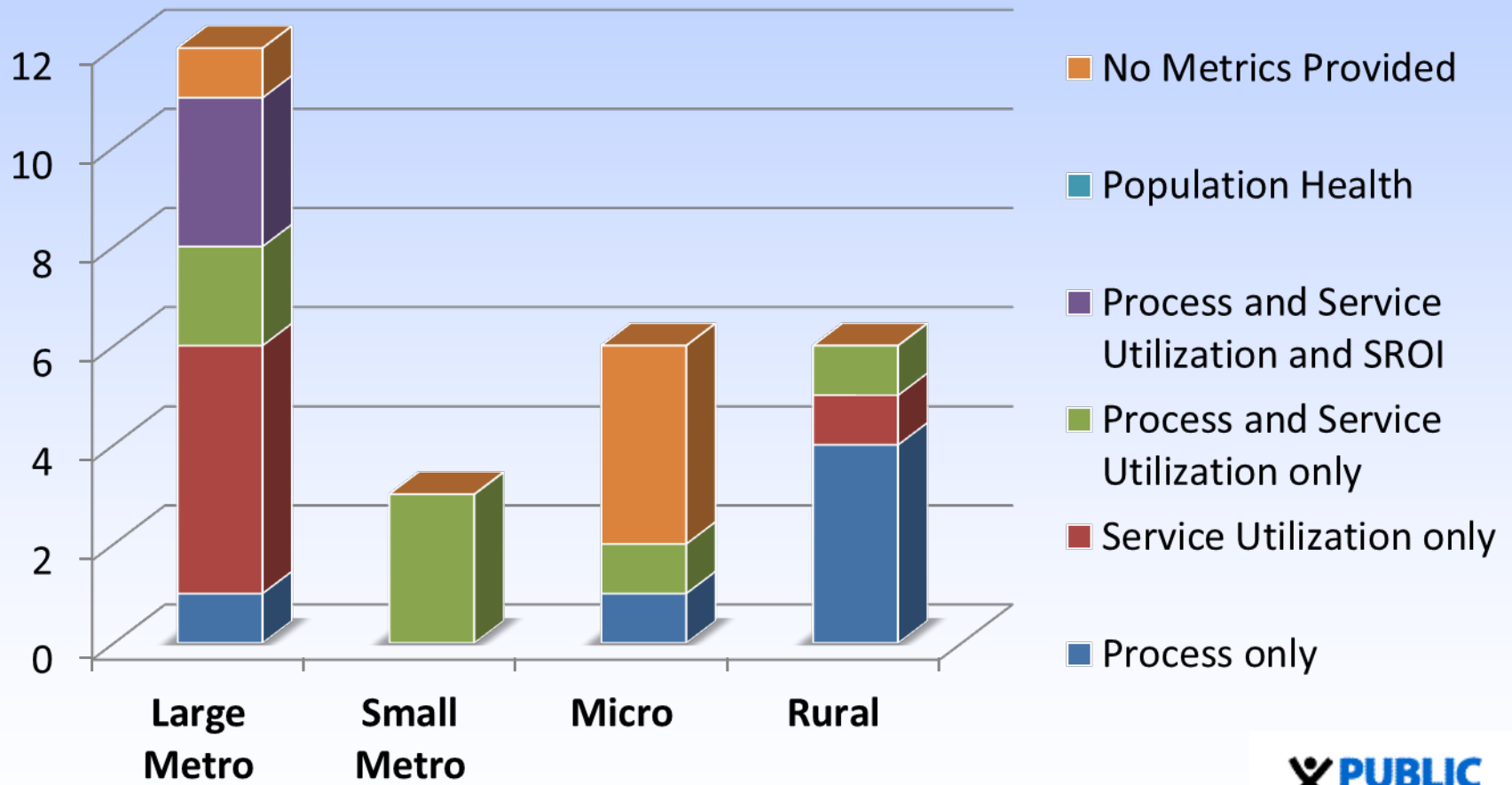# Community Engagement Drop off

Content Focus of Priorities
County Health Rankings Categories

Program Metrics by Region

Health Reform and the Imperative for Alignment

- **Expanded coverage for populations in low income communities**

- **Movement to global budgeting; shift in financial incentives**

- **Drivers of poor health are beyond clinical care management**

- **Business and financial community with shared obligations & interests**

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Coming to Terms with Health Inequities

- **Unhealthy housing**

- **Exposure to array of environmental hazards**

- **Limited access to healthy food sources & basic services**

- **Unsafe neighborhoods**

- **Lack of public space, sites for exercise**

- **Limited public transportation options**

- **Inflexible and/or poor working conditions**

- **Health impacts (e.g., allostatic load) of chronic stress**

Emptiness amongst the Crowd
Wojciech Dziadosz

Opportunities for Alignment

Issue-Specific Assessments (Health Impact Assessment)	Local Health Departments (CHAs/CHIPs)	Tax-exempt Hospitals (CHNAs/ISs)	Community Health Centers (Section 330 Application)	United Ways (CHAs)	Community Action Agencies (Community Services Block Grant Application)	Financial Institutions (CRA Performance Context Review)
When available, HIAs provide an **additional layer of information, most often relating to broader environmental impacts,** in the design of strategies to improve health.	Given reduced public funding,, ongoing collaboration with diverse stakeholders provides an **opportunity to leverage expertise and secure political support** for LHD leadership in monitoring and advancement of **policies that reinforce and sustain improvements in health status and quality of life**.	**IRS allows hospitals to develop ISs in collaboration with other hospitals and State and local agencie**s, such as public health departments. Expanded enrollment and **movement towards global budgeting will require work with others who can help address the determinants of health and** reduce health disparities.	CHCS are **encouraged to link with other providers such as LHDs and hospitals** to provide better-coordinated, higher quality, and more cost-effective services.	UWs have an **established history of collaborating with other stakeholders** in conducting assessments and addressing unmet health needs.	Standard 2.1 **emphasizes partnerships across the community, CAAs can often "serve as a backbone organization of community effort**s to address poverty and community revitalization: leveraging funds, convening key partners…""	Targeted CRA investments in housing, retail, education, and job creation in targeted low-income census tracts that are aligned with parallel interventions and investments of health care and public health stakeholders provide an **opportunity to address social determinants of health and help reduce health care costs**.

WISCONSIN'S SHARED HEALTH PRIORITIES

Karen Timberlake, JD, Director

Bridget Catlin, PhD, Program Director, Mobilizing Action Toward Community Health

University of Wisconsin Population Health Institute

May 21, 2014

University of Wisconsin
Population Health Institute
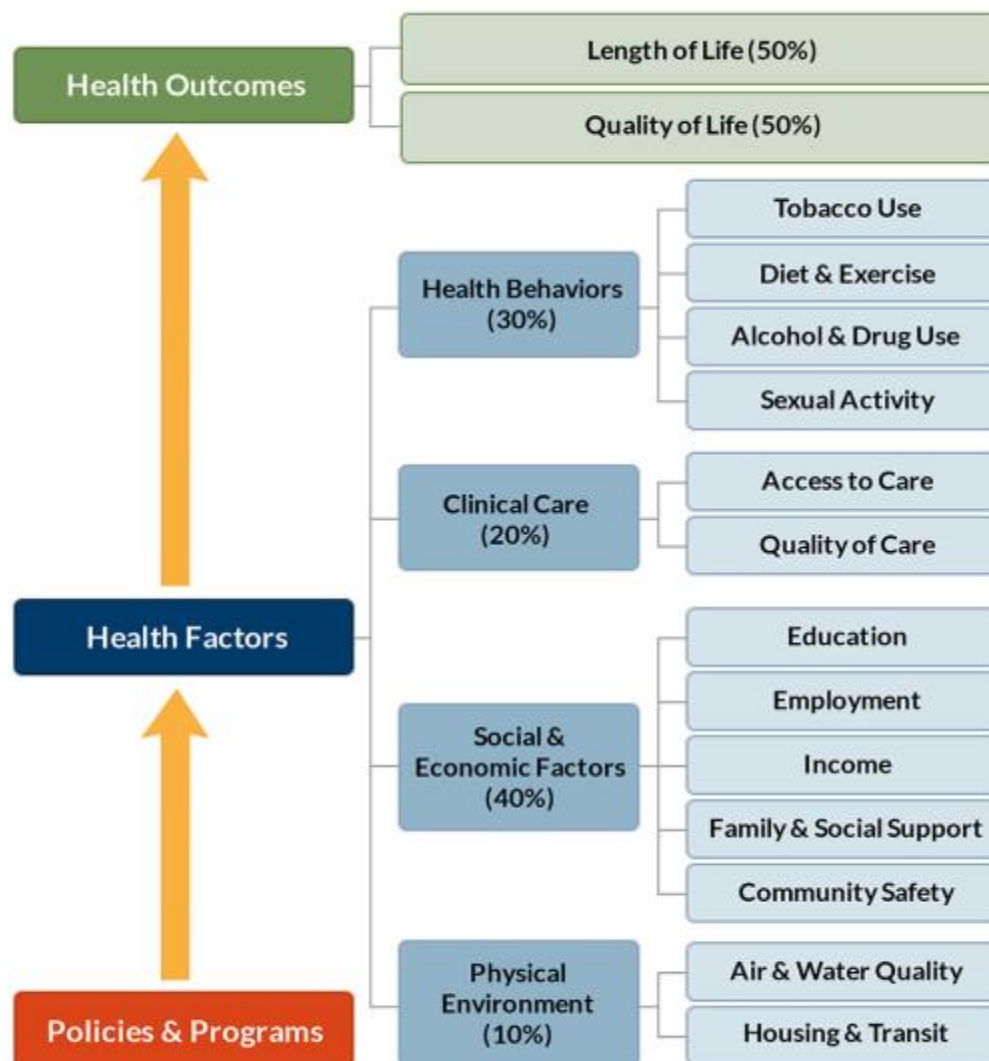SCHOOL OF MEDICINE AND PUBLIC HEALTH

SETTING THE STAGE

- ■ Current sources of health priorities

- ■ "New" opportunities – ACA and community benefit

- ■ Our scan of hospital CHNAs and local health department CHIPs – what did we do?

- ■ What did we find?

- ■ CHNA/CHIPP Improvement Project

- ■ What's next?

County Health Rankings model © 2014 UWPHI

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HEALTHIEST WISCONSIN 2020

- <u>Goals</u>
  - Improve health across the life span
  - Eliminate health disparities and achieve health equity

- 23 focus areas to be addressed by the public health system partners and Wisconsin communities over the decade from 2010 to 2020.

- New:
  - Healthiest Wisconsin 2020 Baseline and Health Disparities Report

Wisconsin Department of Health Services

Healthiest Wisconsin 2020
Focus Areas and Objectives

Crosscutting
Two Focus Areas and Objectives

Eliminate Health Disparities
- Develop comprehensive data to track disparities
- Align resources to eliminate health disparities

Socioeconomic and Educational Determinants
- Develop and promote policies to reduce discrimination and increase social cohesion
- Support and develop policies to reduce poverty
- Support and develop policies to improve education

Other Crosscutting Objectives
- Improve and connect health service systems
- Prepare youth and families to protect their health and the health of their communities
- Promote environments that foster health and social networks
- Evaluate the effectiveness and impact of health policies and programs
- Establish resources for governmental infrastructure

Health
Twelve Focus Areas and Objectives

Alcohol and Drug Use
- Change underlying attitudes, knowledge and policies
- Improve access to services for vulnerable people
- Reduce risky and unhealthy alcohol and drug use

Chronic Disease Prevention and Management
- Promote sustainable chronic disease programs
- Improve equitable access to chronic disease management
- Reduce chronic disease health disparities

Communicable Diseases
- Immunize
- Prevent disease in high-risk populations

Environmental and Occupational Health
- Improve the quality and safety of the food supply and natural, built and work environments
- Promote safe and healthy homes in all communities

Healthiest Wisconsin 2020
Focus Areas and Objectives

Healthy Growth and Development
- Assure children receive periodic developmental screening
- Improve women's health for healthy babies
- Reduce disparities in health outcomes

Injury and Violence Prevention
- Create safe environments and practices through policies and programs
- Improve systems to increase access to injury care and prevention services
- Reduce disparities in injury and violence

Mental Health
- Reduce smoking and obesity among people with mental disorders
- Reduce disparities in suicide and mental disorders
- Reduce depression, anxiety and emotional problems

Nutrition and Healthy Foods
- Increase access to healthy foods and support breastfeeding
- Make healthy foods available for all
- Target obesity efforts to address health disparities

Oral Health
- Assure access for better oral health
- Assure access to services for all population groups

Physical Activity
- Design communities to encourage activity
- Provide opportunities to become physically active
- Provide opportunities in all neighborhoods to reduce health disparities

Reproductive and Sexual Health
- Establish a norm of sexual and reproductive health across the life span
- Establish social, economic and health policies to improve equity in sexual health and reproductive justice
- Reduce disparities in sexual and reproductive health

Tobacco Use and Exposure
- Reduce use and exposure among youth
- Reduce use and exposure among adults
- Decrease disparities among vulnerable groups

Healthiest Wisconsin 2020
Focus Areas and Objectives

Infrastructure
Nine Focus Areas and Objectives

Access to High-Quality Health Services
- Assure access to high-quality health services
- Assure patient-centered health services for all

Collaborative Partnerships
- Identify resources to support partnerships
- Build effective partnerships resulting from respect and empowerment

Emergency Preparedness, Response, Recovery
- Increase integration and partner collaboration
- Increase community engagement

Funding
- Establish stable revenue sources to support health departments
- Effectively use funds available to support health departments

Health Literacy
- Increase awareness of literacy's effects on health outcomes
- Strengthen communication for effective health action

Improve Data to Advance Health
- Exchange data
- Make data accessible
- Use data standards to measure health

Public Health Capacity and Quality
- Strengthen quality in practice
- Achieve public health standards

Public Health Research and Evaluation
- Forge new paths to a healthy Wisconsin
- Take actions that are proven to work
- Target research to reduce health disparities

Workforce that Promotes and Protects Health
- Assure the workforce is prepared to practice in evolving delivery systems
- Establish systems to analyze workforce sufficiency, competency and diversity

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http://www.dhs.wisconsin.gov/hw2020/index.htm

New Resource:

Healthiest Wisconsin 2020 Baseline and Health Disparities Report
An Introduction to the Report

LOCAL HEALTH DEPARTMENTS

- Since 1993, LHDs have been required to conduct Community Health Assessment's (CHAs) & Community Health Improvement Plans (CHIPs)

- Common practice: every 5 years

- Wisconsin has 72 counties and 89 local health departments

WISCONSIN STATE STATUTORY REQUIREMENTS: SEC. 251.05(3) WIS. STATS.

A local health department shall:

(a) **Regularly and systematically collect, assemble, analyze and make available information on the health of the community,** including statistics on health status, community health needs and epidemiologic and other studies of health problems.

(b) Develop public health policies and procedures for the community.

(c) **Involve key policymakers and the general public in determining and developing a community health improvement plan.**

COMMUNITY BENEFIT AND THE ACA

◻ Tax-exempt hospitals must report their community benefits annually to IRS on Form 990, Schedule H

◻ Under the ACA, 501(c)(3) hospital organizations are required to:
  ◻ Conduct a community health needs assessment (CHNA) and adopt an implementation strategy at least once every three years
  ◻ Hospital CHNA must be posted on-line
  ◻ No requirement for Implementation Plan to be available on line
  ◻ Financial penalties for failure to meet the CHNA requirements

CREATE SYNERGY TO MAXIMIZE IMPACT

- Barriers to Alignment
  - Planning timetables -
    - 3 year process for hospitals
    - 5 year process for LHDs
  - Planning together?
  - Lack of awareness of what other organizations are doing to address their communities' priority areas
  - Sheer volume of sources to understand "what's important"

- Opportunities to Align Planning and Implementation Efforts
  - UWPHI scan of most recent CHNAs and CHIPPs
  - CHIPP infrastructure improvement project
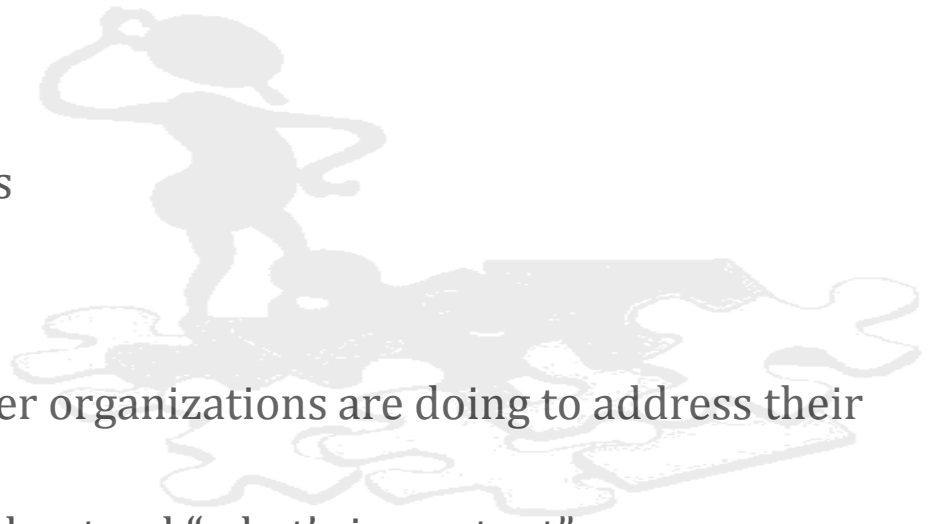
STARTED WITH DATA COLLECTION

- Collected both **hospital and LHD CHNA's**
  - Coded all plans by priority area to analyze common priorities
  - Eight top themes emerged and overlapped between hospital and LHD plans

- Collected LHD CHIPs and hospital **implementation plans**
  - Based on the top eight priority areas, then gathered strategies and tactics relevant to each priority area
  - Only strategies and interventions that pertained to the top 8 priorities were collected

PRELIMINARY FINDINGS

Wisconsin's Shared Health Priorities (Alphabetical)

1) Access to care

2) Alcohol Use

3) Drug Abuse (Prescription and Illicit Drugs)

4) Mental Health

5) Nutrition

6) Obesity

7) Physical Activity

8) Tobacco

Minnesota outscores Wisconsin on 39 health measures, UW study finds

By Susan Perry | 01/24/13

Wisconsin has the highest percentage of excessive drinkers among all 50 states.

BROAD THEMES

- Substance abuse
  - Broken down into excessive alcohol use and prescription/illicit drug abuse categories

- Access to Care
  - Includes acute/primary, behavioral health, and dental

- Obesity
  - Separate category even if physical activity and nutrition priorities were also listed

- Chronic disease management, prevention and wellness
  - Broken down by specific priority area since most of the top eight priorities were found under this category

ASSUMPTIONS AND LIMITATIONS

- Some implementation strategies targeted more than one priority in certain strategies. This is evident within implementation snapshots.

- Not all plans for hospitals and LHDs were included
  - LHD
    - Different timeframe for completion
    - Any outdated plans were not included
  - Hospital
    - No IRS requirement to post Implementation plan on line
    - Different fiscal year end dates
    - Implementation plans are already changing

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Assessing and Improving Community Health in Wisconsin

About the Project   Shared Priorities   Tools and Resources

What are organizations working on in my county?
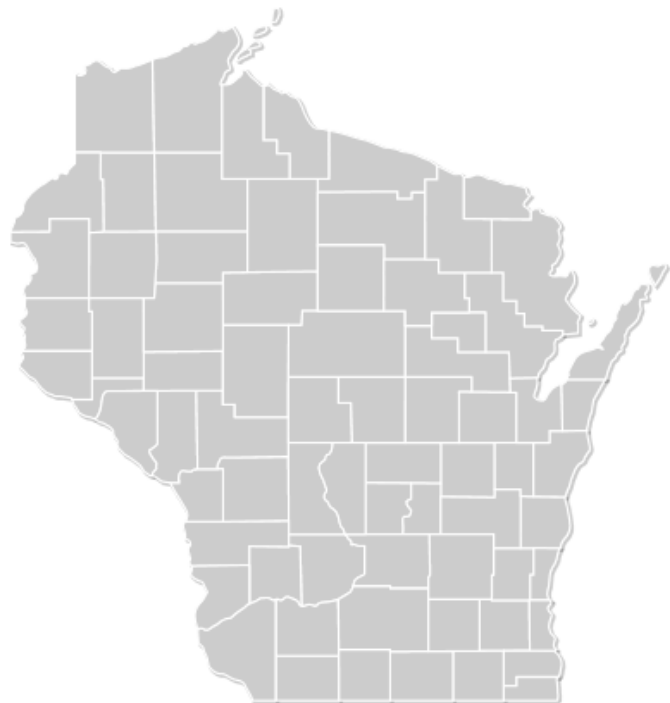
What organizations are working on my topic?

Access to Care
Alcohol Use
Drug Use
Mental Health
Nutrition
Obesity
Physical Inactivity
Tobacco Use

Assessing and Improving Community Health in Wisconsin

Ashland County

By Priority

Excessive Alcohol Consumption (Alcohol)	Memorial Medical Center-Ashland
Prescription and Illicit Drug Abuse (Drug Abuse)	Ashland County Health and Human Services Department Memorial Medical Center-Ashland
Mental Health Needs/Issues (Mental Health)	Ashland County Health and Human Services Department
Nutrition	Ashland County Health and Human Services Department
Physical Activity	Ashland County Health and Human Services Department
Tobacco Use	Ashland County Health and Human Services Department

By Organization

|	
Ashland County Health and Human Services Department	Prescription and Illicit Drug Abuse (Drug Abuse) Mental Health Needs/Issues (Mental Health) Nutrition Physical Activity Tobacco Use
Memorial Medical Center-Ashland	Excessive Alcohol Consumption (Alcohol) Prescription and Illicit Drug Abuse (Drug Abuse)

Assessing and Improving Community Health in Wisconsin

| About the Project | Shared Priorities | Tools and Resources |

Excessive Alcohol Consumption (Alcohol)
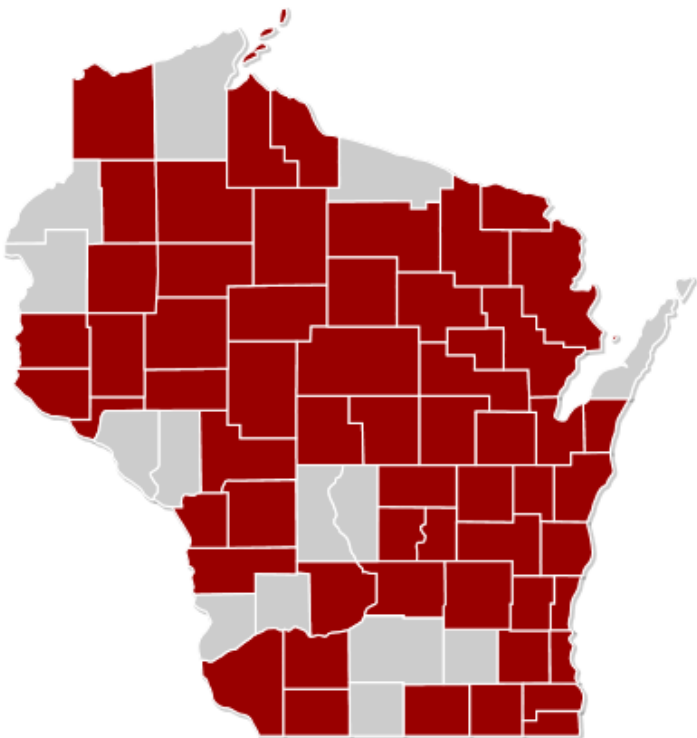
Hospitals
Appleton Medical Center
Aurora BayCare Medical Center
Aurora Lakeland Medical Center
Aurora Medical Center in Grafton
Aurora Memorial Hospital of Burlington
Aurora Psychiatric Hospital
Aurora Shebyoygan Memorial Medical Center
Aurora St Luke's Medical Center
Aurora St Luke's South Shore
Baldwin Area Medical Center
Beaver Dam Community Hospitals
Bellin Health Oconto Hospital
Bellin Memorial Hospital
Bellin Psychiatric Center
Black River Memorial Hospital
Calumet Medical Center
Chippewa Valley Hospital
Columbia St. Mary's Hospital Ozaukee
Columbus Community Hospital

Local Health Deparments
Appleton City Health Department
Barron County Health and Human Services Department
Brown County Health Department
Calumet County Health Department
Chippewa County Department of Public Health and Home Care
DePere Department of Public Health
Douglas County Department of Health and Human Services
Dunn County Health Department
Florence County Health Department
Fond du Lac Health Department
Forest County Health Department
Green Lake County Department of Health & Human Services
Greendale Health Department
Iron County Health Department
Jackson County Health & Human Services Department
Kenosha County Job Center/Human

Assessing and Improving Community Health in Wisconsin

Appleton Medical Center
1818 N MEADE ST
APPLETON, WI 54911
Outagamie County

Go to Website

Implementation Approaches

Access to Care	Alcohol	Drug Abuse	Mental Health	Obesity

PRIORITY: Substance Abuse (italics indicate an initiative currently underway)
GOAL:
Reduce incidence of alcohol/drug abuse

OBJECTIVE #1:
Mobilize community to action on alcohol and drug use

ACTION PLAN

| Activity	Target Date	Anticipated Impact
Organize local "plunge" on alcohol/drug use for community leaders	December 2016	Collaboration to meet gap(s) identified in plunge

RESOURCES TAB

- *County Health Rankings & Roadmaps*
  - Data, tools, strategies for change (including What Works for Health)
  - http://www.countyhealthrankings.org

- Healthiest Wisconsin 2020 Baseline and Health Disparities Report
  - Baseline data by topic for the HW2020 focus areas, and documentation of health disparities in Wisconsin populations and communities.
  - http://www.dhs.wisconsin.gov/hw2020/hw2020baselinereport.htm

- Wisconsin Guidebook on Improving the Health of Local Communities
  - Assessment, Implementation and Evaluation resources
  - http://www.walhdab.org/NewCHIPPResources.htm
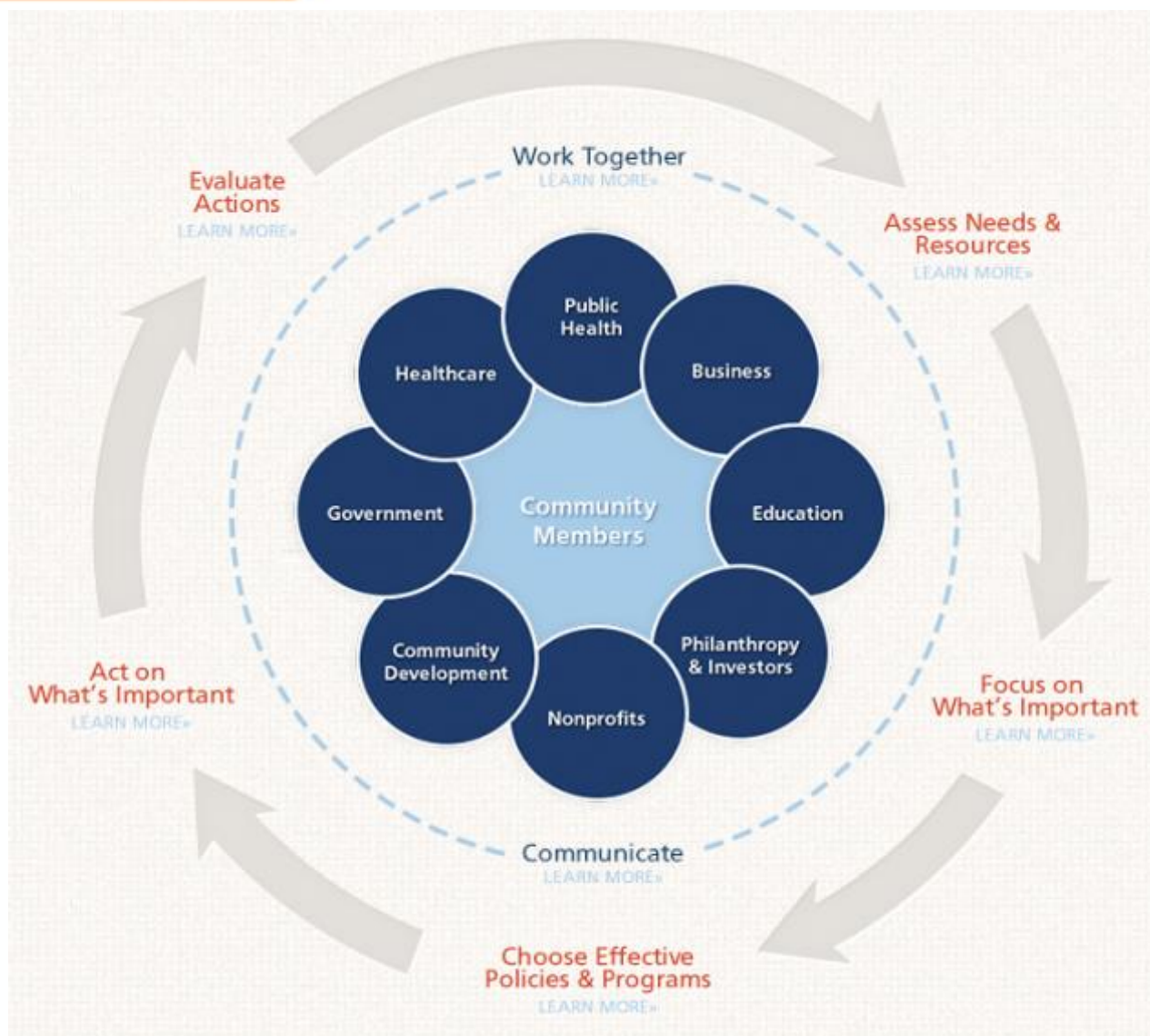
ALCOHOL: Iron County LHD

New Strategies and Activities:
Engage community members in coalition building to assist in implementing strategies to address alcohol and other drug use by utilizing existing committees such as Integrated Family Services (IFS).
Educate parents and other caregivers about the negative impacts of alcohol and other drug use on brain development
Offer evidence-based programs for parents and other caregivers such as "Parent's Who Host, Lose the Most" and "You Use, You Lose" to reduce non-commercial access of alcohol to minors.
Create built environments in the community that promote alcohol/drug free activities for youth and families such as the Iron County Memorial Building Project
Offer evidenced-based alcohol and other drug programs in schools such as "All Stars" which targets middle school age students, Athena (Athletes targeting healthy exercise and nutrition) targeting female student athletes, and Atlas (Athletics training and learning to avoid steroids) targeting male student athletes).
Implement a teen "peer" court program to divert youth with substance abuse treatment needs from entering the juvenile justice system

PERFORMANCE MEASURES

OBJECTIVE #1 by December 31, 2016, a decrease in unhealthy and risky alcohol and other drug use by changing attitudes, knowledge and policies, and by supporting services for prevention and screening interventions, treatment and recovery. Measurement tools include the Behavioral Risk Factor Surveillance (BRFS), Youth Behavioral Risk Surveillance (YBRS), and Wisconsin Department of Health Services (WDHS)

OBJECTIVE #2 by December 31, 2016, evidence-based alcohol and other drug abuse prevention programs will be offered in all Ashland County and Bayfield County schools. Measurement tools include BRFS , YBRS, and WDHS.

OBJECTIVE #3 by December 31, 2016, Ashland and Bayfield counties will support Alcohol and Other Drug Use Coalition work that increases community knowledge of alcohol and other drug use issues and drives action towards broad range policy changes.

MENTAL HEALTH: Wheaton Franciscan All Saints in Racine

How we'll respond to the need:

- Improve access for children with mental health issues by addressing barriers to care.
- Improve access and services to children in need of mental health services in Racine County.
- Educate and promote understanding and awareness with community local law enforcement and community stakeholders on mental health issues that impact our community.
- Redesign Racine County's Juvenile Detention system to address access to mental health services for children.
- Implement Crisis in Intervention Training.
- Implement Crisis in Partnership Training.
- Partner with National Alliance on Mental Illness to provide community education programs that increase awareness of mental health issues.

MENTAL HEALTH: Burnett Medical Center

Objective #2: Increase awareness of mental health services

Implementation Activities:

1. Burnett Medical Center will partner with local organizations to support the "I am STRONGER than you think" public awareness campaign created by Northwest Passage, Ltd designed to inspire more people to seek mental health services for themselves and others by reducing the stigma associated with mental health. Possible campaign activities include hosting or participating in events such as community fairs, runs/walks, and other fitness-related events.

2. Burnett Medical Center will help fund the creation of a brochure of alternative resources available in Burnett County to address mental health concerns, including spiritual and alternative treatment avenues. Burnett Medical Center will have this brochure, as well as a brochure of traditional mental health services in Burnett County—counseling, psychiatric, and psychological services—available at the medical facility.

3. As a lead partner of Healthy Burnett, Burnett Medical Center will support other activities designed to increase awareness of mental health services, including the public awareness campaign created by the Burnett County Mental Health Task Force designed to increase awareness and utilization of the Mental Health Crisis line.

DRUG ABUSE: Langlade LHD

Outcome:
By 2015, a minimum of four strategies will be implemented that raise awareness of the dangers of illegal drugs, including the misuse of prescription drugs and painkillers.

Suggested Strategies to Accomplish Outcome
- ✓ Encourage medication disposal and seek to secure funding for the disposal.
- ✓ Complete a Social Norms Campaign to capitalize on positive peer pressure.
- ✓ Support positive alcohol and drug free activities and groups, such as Boy Scouts, 4-H, Boys and Girls Club, and Church youth groups.
- ✓ Support the creation of a registry to track commonly abused prescription drugs.
- ✓ Develop a presentation for parents on the access to prescription drugs and painkillers via the internet.
- ✓ Secure funding for programs that discourage drug use and encourage healthy living and behaviors.
- ✓ Provide education to youth, parents, and teachers about the drugs that are out there and what the dangers of those drugs are.
- ✓ Support having a relationship between the schools and the police through support of the DARE program and of a liaison officer.
- ✓ Facilitate community conversations about drug related issues and urge action.
- ✓ Write a series of articles for the newspaper that focuses on prescription drug abuse.
- ✓ Write a series of articles for the newspaper that focuses on illegal street drugs.

DRUG ABUSE: Shawano Medical Center

OBJECTIVE #1:
Mobilize community to action on alcohol and drug use

ACTION PLAN

Activity	Target Date	Anticipated Impact
Organize local "plunge" on alcohol/drug use for community leaders	October 2013	Collaboration to meet gap(s) identified in plunge

OBJECTIVE #2:
Reduce underage drinking and drug use

ACTION PLAN

Activity	Target Date	Anticipated Impact
Work with existing AODA Task Force to support their efforts	December 2016	Fewer parents providing/ allowing alcohol for youth under 21
Provide financial assistance and in-kind support to local AODA Task Force for "Binge Drinking" social norms campaign	December 2015	Heightened awareness of excessive alcohol use
Provide financial support for Chem-free graduation/prom parties	Annual	No serious alcohol-related accidents
Host "Party at the PAC" to educate teen drivers about risks of alcohol/substance abuse and driving	Annually in March	Reduced number of teen vehicle accidents involving alcohol/ drugs

DRUG ABUSE: Shawano Medical Center

OBJECTIVE #3:
Implement system policy changes that provide for early detection/prevention of alcohol and drug use

ACTION PLAN

Activity	Target Date	Anticipated Impact
Explore possibility of implementing SBIRT (Screening, Brief Intervention and Referral for Treatment) clinical protocol to screen for substance abuse and refer for help	December 2016	Early identification and treatment
Explore establishment of system policy around prescription practices that impact heroin use	December 2015	Targeted action to reduce epidemic of use
Implement policy regarding sponsorship of community events that negatively endorse alcohol use	December 2014	Increased success of health-oriented community events

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PHYSICAL ACTIVITY: Mayo Clinic Health System: Chippewa Valley

Implement youth focused wellness programming in Chippewa County. Mayo Clinic Health System manages a variety of community wellness programs targeted for children and families. We will work with area partners and stakeholders to implement these programs in the Chippewa Valley area.

Increase participation from Chippewa County in Camp Wabi - Camp Wabi is a partnership between Mayo Clinic Health System and the Eau Claire YMCA designed to help kids ages 10 to 14 who struggle with obesity make lifestyle changes necessary to achieve a healthy weight. This program is open to all youth in the region. We will actively promote this opportunity to youth in the Chippewa Valley service area.

Better utilize and expand on existing community resources. – There are many existing opportunities and community resources designed for youth physical activity. We will partner with community stakeholders to increase use of those resources.

NUTRITION: St. Joseph's Hospital, Chippewa Falls

CHIP has convened a food security initiative and will continue assessment of evidence-based strategies to combat food insecurity. A survey will be completed of area food pantry directors to identify barriers that they experience to providing services to food pantry patrons and an action team will be developed to work with food pantry directors to overcome these barriers.

SJCF will do at least one food collection per year for area food pantries.

A food audit will be completed in Chippewa County of grocery stores, markets, farmers markets, convenience stores, food distributors, etc. to ascertain the availability of fresh fruits, vegetables and low fat dairy and prices of same. This information will be used to identify food deserts in the SJCF service area and planning will begin to work toward reduction of food deserts in the area.

County Health Rankings model © 2014 UWPHI
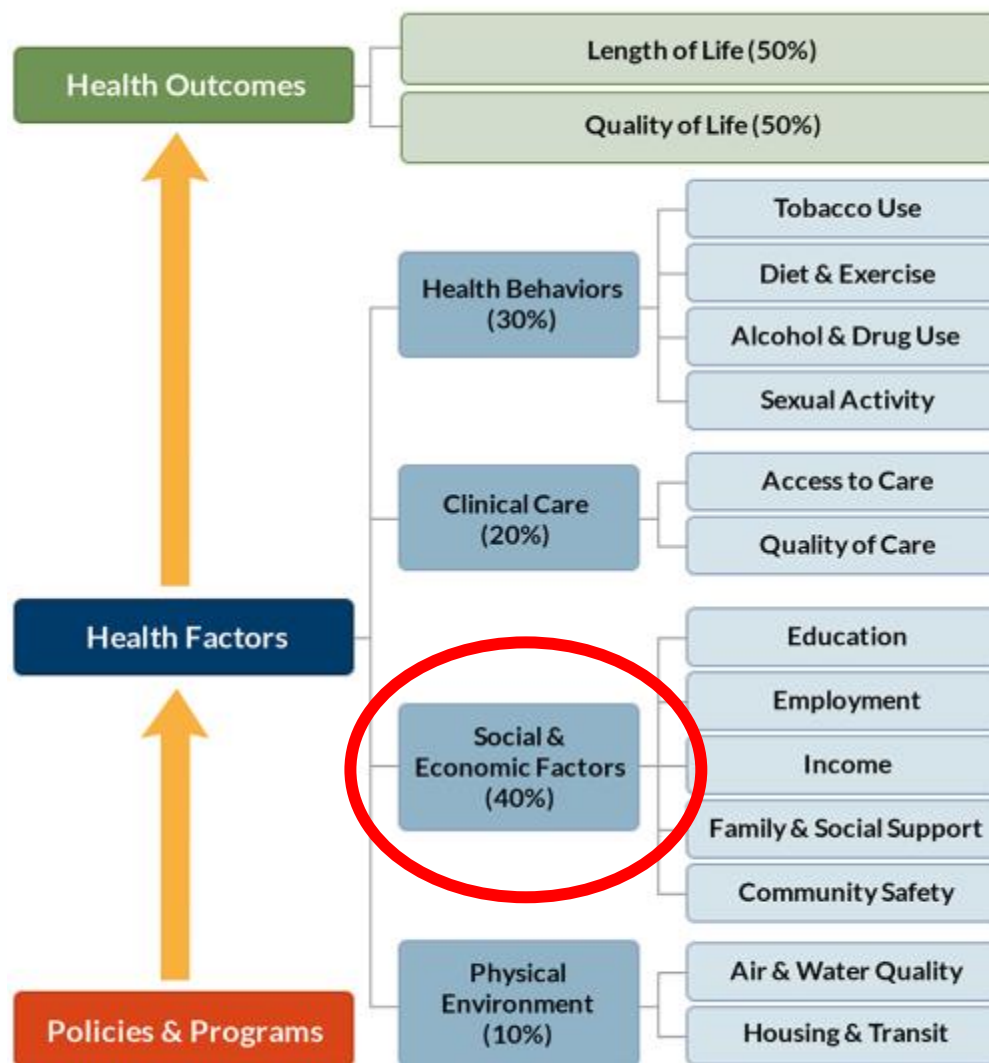
SOCIAL/ECONOMIC DETERMINANTS OF HEALTH

24 LHDs and 20 hospitals prioritized social and economic determinants of health.

- Education
  - Academic Achievement gap
  - High school graduation rates
- Employment/Unemployment
- Community Safety
  - Injury and Violence Prevention
  - Violent Crime
  - Youth safety/injury prevention
- Income
  - Poverty/ Financial hardship
- Social Support
  - Parenting
  - Focusing on high-risk families

EARLY FEEDBACK: HOSPITALS

- Powerful

- Creates opportunities for hospitals to reengage community in implementation

- Wisconsin Hospital Association will partner in dissemination, promotion

- Implementation plans are already changing – "no budget"

- "Let me explain why we didn't…."

EARLY FEEDBACK: PUBLIC HEALTH

- What about FQHCs, tribal health clinics, United Ways?

- We will use this analysis to find partners across the state

- Can we get the whole spreadsheet? (Environmental health)

- If we get these 8 right, we will positively impact the social/economic determinants

- How can we use this to educate policy makers on a policy agenda that aligns with these priorities?

- State Health Department: Will reenergize the State Health Plan

- How will you keep this updated?

Evaluating QUALITY OF CHNA and CHIP

- Step 1: Develop CHIPP Quality Measurement Tool

- Step 2: Measure the quality of Wisconsin's 94 CHIPPs

- Step 3: Conduct a comparative analysis to determine if there are any structural or process factors that predict higher quality CHIPPs

CHIPP Quality Measurement # of Items by CHIPP Stage

CHIPP Stage	Document Review	LHD Survey	Total
General	6	1	7
Work Together	5	4	9
Assess	11	0	11
Prioritize	4	0	4
Choose	3	0	3
Implement	4	3	7
Evaluate	4	0	4
TOTAL	37	8	45

CHIPP Quality Measurement # of Items by PHAB Domain

PHAB Domain	# of Items
Domain 1: Conduct & Disseminate Assessments	18
Domain 3: Inform & Educate the Public	2
Domain 4: Engage with the Community	3
Domain 5: Develop Policies & Plans	20
Domain 11: Administrative & Management Capacity	1
Literature Review	4
TOTAL*	48

*Some items are counted in two domains

CHIPP Stage Results (N=94)

CHIPP Stage	Mean Score (Maximum=4)
General	3.19
Assess	3.13
Prioritize	2.74
Choose	2.72
Work Together	2.71
Implement	2.52
Evaluate	1.60

Highest Scoring Items

Item	CHIPP Stage	Mean Score (Maximum Score=4)
There is evidence of secondary data collection.	Assess	3.74
Data are collected in multiple health factor areas, showing a consideration of the multiple determinants of health.	Assess	3.71
The CHIPP acknowledges state and national priorities.	General	3.66
A variety of data sources are used to describe the community.	Assess	3.55
Local data are compared to other agencies, regions, state, or national data.	Assess	3.55
A formal model, local model, or parts of several models are used to guide the CHIPP.	General	3.53

Lowest Scoring Items

Item	CHIPP Stage	Mean Score (Maximum Score=4)
The local community at large has had the opportunity to review and comment on the CHA &/or CHIP.	Work Together	1.09
Revise the CHIP based on evaluation results.	Evaluate	1.32
CHIP contains a plan for performance indicators for strategies.	Evaluate	1.62
Monitor progress on implementation of strategies in the CHIP in collaboration with stakeholders and partners.	Evaluate	1.62
CHIP contains a plan for measurable health outcomes.	Evaluate	1.83
CHIP identifies individuals and organizations that have accepted responsibility for implementing strategies.	Implement	1.87

Lessons Learned

- Strengths in Assessment and Prioritization reflects history of state-mandated CHA

- Opportunities:
  - Strengthening the movement to the left side of the action cycle (Implementation & Evaluation)
  - Developing and disseminating a self-assessment tool
  - Informing collaborative work with not-for-profit hospitals

QUESTIONS AND DISCUSSION

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Wisconsin
Partnership Program
Improving the health of people in Wisconsin

THANK YOU

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http://uwphi.pophealth.wisc.edu/programs/match/healthiest-state/index.htm

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