Health Assessments and Community Engagement – Trinity Health

Community Collaborative use in Health Assessment, Strategic Prioritization and the Implementation of Community Benefit Programming - Lessons from Trinity Health

Presentation by

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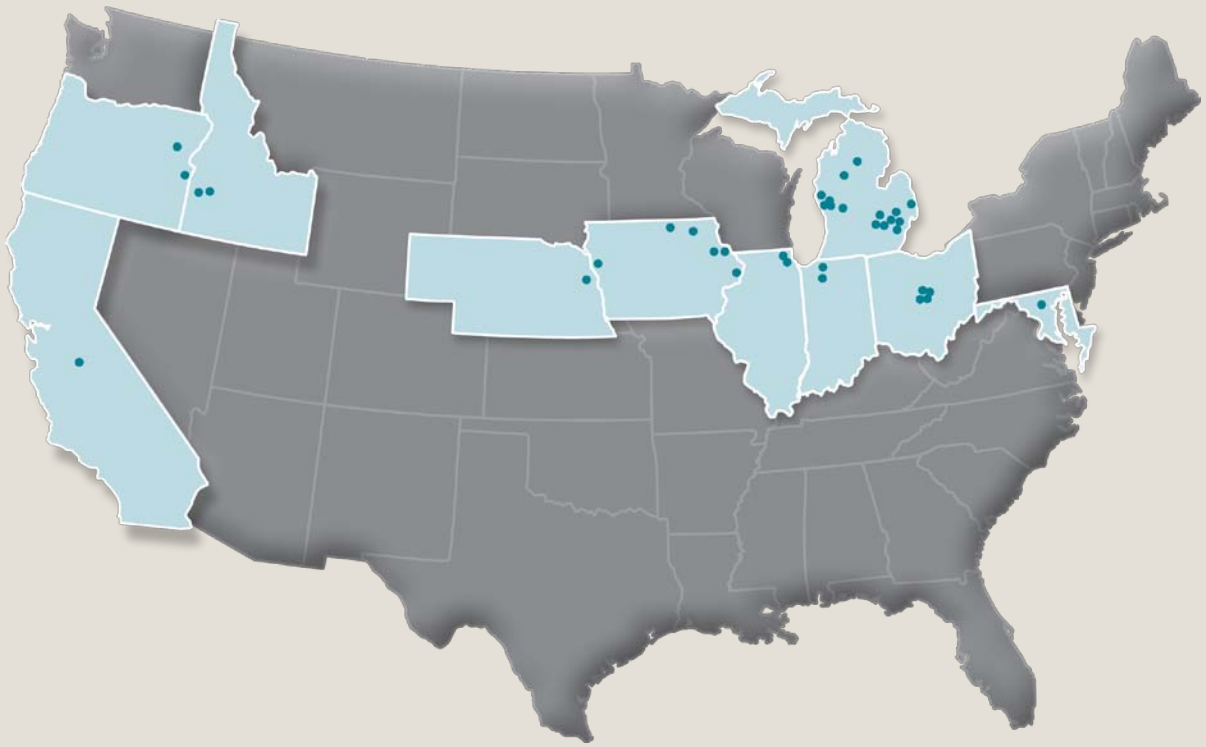
Trinity Health: Unified Enterprise Ministry

Serving Nine States Nationwide



- Fifth-largest Catholic health system in the United States (based on Net Patient Revenue)
- 46,000 full-time equivalent employees
- More than 8,000 active staff physicians (over 1,000 employed)
- 19 Ministry Organizations, encompassing 46 hospitals 34 owned, 12 managed
- 379 outpatient centers
- Revenues of $7 billion
- Over $455 million in Community Benefit Ministry

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Novi, Michigan

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Catholic Healthcare – Assessing Need and Acting!

Landing of the Ursulines,
by Paul Poincy

The Health Project: Grassroots Engagement

Health Project Collaboration History

- Health Project launched in Muskegon 1995
  - Partnership Grant from W. K. Kellogg Foundation (CCHMs)
- Community is Stakeholder in Health Care
  - Inclusive Participation
  - Board representation/Payers, Providers, Consumers
- Outcomes Included creation of Access Health in 1999
  - National model for HRSA SHAP grants
  - 17 communities in 5 states
- Community Benefit relationship established with MHP - 2008
  - Acquired by Trinity Health Systems 2010
  - External Community Benefit Program for Mercy Health Partners
  - Operate as Pilot Site and CB Technical Assistance for Trinity Health

Our Approach -Trinity CHNA Toolkit - 2008

- Establish Meaningful Engagement through Collaboratives
  - Seek out Stakeholders (e.g.United Way, FQHC's, other hospitals, Com. Mental Health) who must assess
  - Share costs of process
  - Use Common Benchmarking of Community – e.g. County Indicators
- Emphasize Input from broad interests of community
  - Quantitative – traditional demographics
  - Qualitative – strongly recommend
    - Forums
    - Conversations
    - Sector Affinity (Focus) Groups
- Public health expertise or involvement
- Make widely available to the community

Meaningful Engagement – TH Process

Exhibit 3: Collaborative Partners Resource Grid

Use this tool as a guide to select potential partners in the MO locale likely to assist with data collection and obtaining community input.

Potential Partner	Data Type/Other Assistance	Contact Person	Phone	E-mail
☐ United Way	Human Service Information Volunteers			
☐ School District/MAISD	Education, Poverty, Volunteers			
☐ Call-211	Assistance Needs			
☐ Community-Based Orgs. Urban League Community Action Against Poverty Head Start Early Start Volunteer Organizations Service Organizations	Poverty Needs Volunteers – Community Input			
☐ Faith-Based Organizations: MO Pastoral Staff Pastoral Committee Council of Churches Others:	Volunteers – Community Input Local Church Attendance data and/or trends			
☐ Physicians: Fed. Qual. Health Cntrs. (FQHC) Other Clinics serving poor Medical Societies Physician Health Organizations MO Primary Care Networks	Health Information, Surveys and Focus Group Participation			
☐ Chamber of Commerce	Community Information Business Volunteers – Community Input			
☐ Government Grantees (Public Health, Health & Human Services, Housing & Urban Development)	Community Information Needs Data			
☐ City Planning Dept.	Community Information			
☐ County Planning Dept.	Community Information			
☐ Regional Planning Agency	Community Information State's and Local Census Data TA/Contractor			
☐ College/University	Community information Contractor Volunteers – Community Input			
State Dept. Human/Social Services	Poverty Human Services info, Risk Factor Surveys			
☐ State Dept. Public Health	Health Data, Risk Factor Surveys			
☐ US Census	All			
☐ Private Data Firms	All Data Contract			
☐ Private Planning/ Marketing Firms	Contractor for Assessment			

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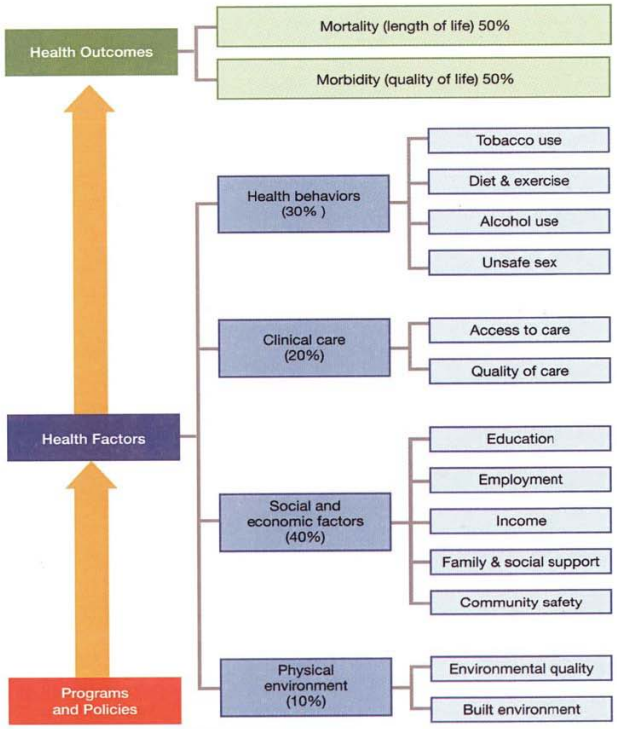
Integration of Public Health Tools

The Rankings

This report ranks Wisconsin counties according to their summary measures of **health outcomes** and **health factors**, as well as the components used to create each summary measure. The figure below depicts the structure of the *Rankings* model. Counties receive a rank for each population health component; those having high ranks (e.g., 1 or 2) are estimated to be the "healthiest."

Our summary **health outcomes** rankings are based on an equal weighting of mortality and morbidity measures. The summary **health factors** rankings are based on weighted scores of four types of factors: behavioral, clinical, social and economic, and environmental. The weights for the factors (shown in parentheses in the figure) are based upon a review of the literature and expert input but represent just one way of combining these factors.



County Health Rankings model ©2010 UWPHI

Inclusive Community Input

This template provides a variety of approaches and implementation prompts from which to select those who are well-suited to your MO. In conjunction with Exhibit 7-"Collaborative Partners Resource Grid," it can be used to help procure volunteers and in-kind contributions.

Exhibit 7: Community Input & Methods Selection Grid

Input Type	Who? (Interest Sector –see * below)	Lead Person or Community Partner	Sample Size	How? (Hand, mail, phone, web)	Where? (Public, Business, Event, Media)	When?	Cost?
☐ Questionnaires/ Surveys							
☐ Interviews							
☐ Focus Groups							
☐ Expert Panels							
☐ Public Panels							
☐ Town Meetings							
☐ Media Polls							
☐ Individual Stories							

Interest Sectors:

Health Providers	Businesses	Seniors	Elected Officials
Human Service Providers	Faith-Based Organizations	Youth	Educators
Government Offices	Community-Based Organizations	Disabled	Organized Labor
Neighborhood Organizations	General Public	Media	

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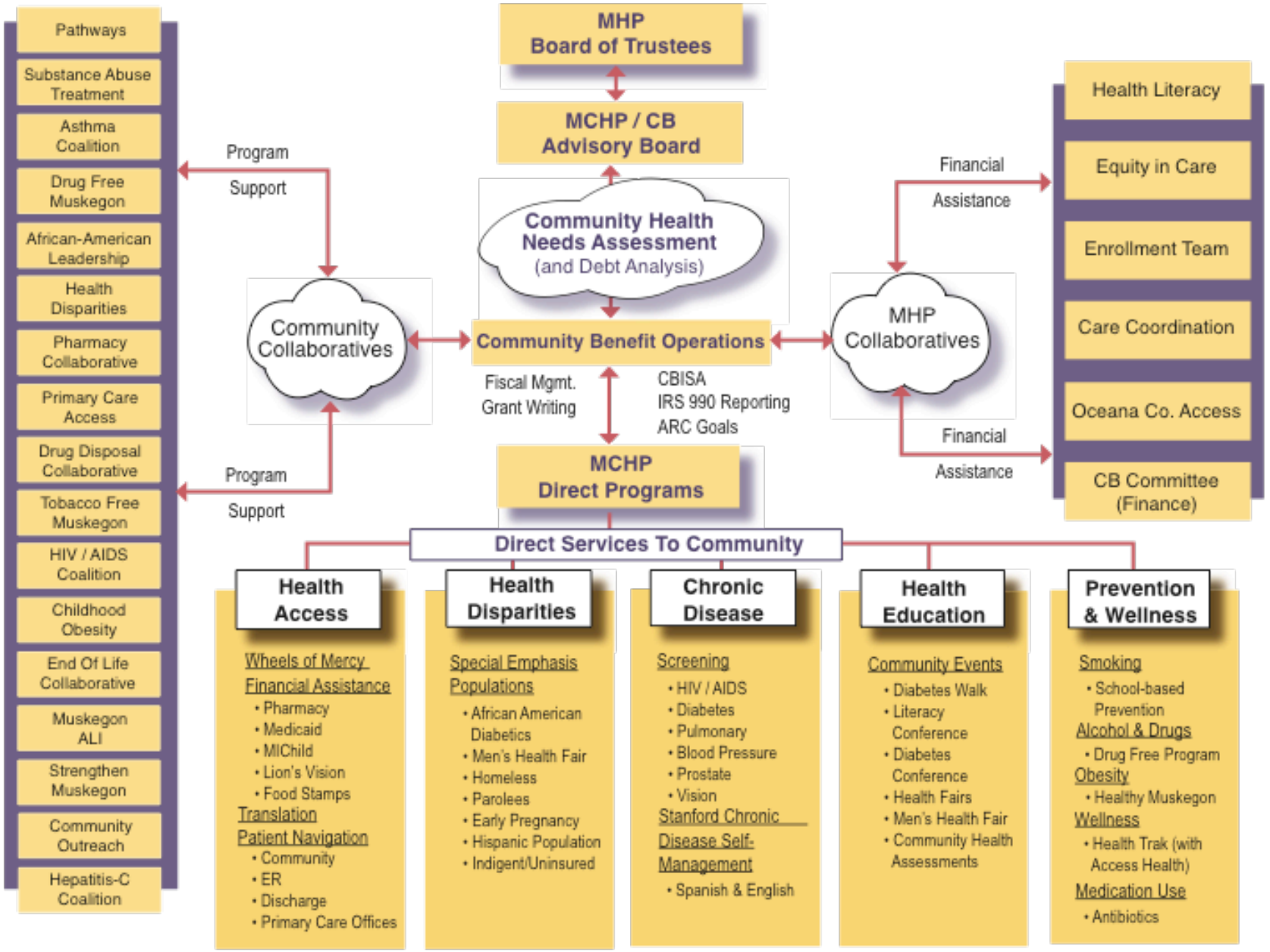
Prioritization of Need

- Identify health needs through CHNA Process
- Develop strategic priorities…let data and input determine agenda
  - Severity of problem: quantitative data/surveys
  - Intensity of need: GeoMapping/spikes/qualitative data
  - #'s of people affected
  - Cost
  - Gaps
- Perceptions of Need
  - Qualitative
  - Stories
  - Reality
- Use of "Super Collaborative"

The Action Strategy – After Priority Setting

- Engage existing stakeholders and community members
  - Provide infrastructure and administrative support
- Develop or support coalitions to address CHNA priorities
  - New Programs
  - Enhance Old Programs
  - Initiate Research
- Coordinate collaborative community-based health services
  - Link to provider based health delivery system
  - Link to other resources
  - Target Geographically or Demographically
- Monitor activities and track health outcomes – centrally
  - Develop sustainability and shared investment
- Report community benefit

Community Health Collaborative Infrastructure



Linking CHNA to the Web and Social Media

Process Wins

- Using community health collaboratives can improve the community health delivery system
- Community benefit programming can play a key role in targeting and implementing successful community health strategies
- Combining the use of community health collaboratives with the goals of the Health Assessment can reduce cost and help to build sustainability
- In communities with competitive medical environments a collaborative can convene as a neutral body

Challenges for Consideration

- Coalition use is considered “Community Building” and not reportable on the 990h
- Local Public Health is often weak, underfunded, and subject to political agendas of local county governance
- Tendency by federal Policy Makers is to be too prescriptive
- Tracking outcomes – Information systems are inadequate to manage and track what we do
- Questions about Health Reform impact make it difficult to plan
- Evidence based programming limits innovation and opportunity

Questions?

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