



**Hospital Council of Northwest Ohio (HCNO) Approach to Local Collaboration in Community Health Assessment (CHA) & Community Health Improvement (CHIP) Processes
December 2016**

This document describes the approach used by HCNO in working with local health departments, hospitals and other partners in over 40 counties in Ohio.

The key to a successful Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) starts with collaboration. Collaboration is important for so many reasons including: funding the CHA and CHIP (present and future); choosing a comprehensive set of indicators for the county survey; planning (choosing priorities for the future); and reducing duplication of processes and/or services.

At what level should collaboration happen?

Most sectors/partners do their work at the county level, so completing a CHA and CHIP at the county level generally makes the most sense. County-level agencies such as the behavioral health/mental health board, Jobs and Family Services, county commissioners, or the Sheriff's office may not be interested in work being done just in one area of the county. However, a county can always drill down to specific communities or neighborhoods later in the process to look at specific zip code data or when creating action steps if needed. This is especially important for hospitals that need to look at their primary service area data. In addition, if all counties in a region are using the same process and indicators for their CHA, the work can be rolled up to the regional level. This allows for the regional hospital association to be more involved in the process, many times resulting in spearheading initiatives at the regional level. This also allows for more collaboration between the smaller, rural counties to secure grant funding as a mini-region.

Should various types of counties use different processes or indicators?

The simple answer is no. Regardless of the county size, demographics, or area (urban, rural, suburban, or Appalachian), a similar process and a core set of indicators should be used. When collecting primary data, HCNO uses a set of 70 core indicators for adults, 60 core indicators for youth, and 50 core indicators for children. These indicators come mostly from national surveys (BRFSS, YRBSS, and National Survey of Children's Health (NSCH)) so not only can the counties compare themselves with one another they can also compare themselves with the state and nation. The process used in the 40+ counties we work in, is used in urban areas such as Lucas County (Toledo) as well as rural areas such as Defiance County. For this reason, each county also has a number of "alternate" questions they add to their surveys to "make it their own". So for example, Erie County (located on the lake) may ask questions about water safety and Henry County may ask a question about farm safety. Urban communities may want to ask questions about neighborhood safety. Another added benefit of using the same process and core indicators is that hospital systems (that have hospitals in multiple counties) can engage in the process at the county-level and roll up the data to the hospital system level, therefore eliminating the need for the hospital system to do their own assessment separately.

Who should be a part of our CHA and CHIP Committee?

HCNO recommends including the following organizations/sectors on your CHA and CHIP committee:

- Hospitals (CEO, other administration, physicians)
- Health Departments (Health Commissioner, Director of Nursing, health educators, accreditation coordinators)
- Federally Qualified Health Centers (FQHCs)
- Community Agencies (United Way, Family and Children First Council, Job and Family Services (JFS), Behavioral health board (often referred to as mental health board or Alcohol Drug and Mental Health Board [ADAMH], Board of Developmental Disabilities)
- Elected Officials (state, county commissioners, mayors)
- Schools (superintendents, principals, guidance counselors, board members)
- Law enforcement (police, fire, courts)
- Religious Organizations (pastors, youth ministers)
- Businesses (Economic Development Corporation, Chamber, Rotary, local businesses)
- Managed care/insurance plans

A county should consider not moving forward with the process if the sectors above are not represented. The convener of the committee may need to spend extra time reaching out to the sectors prior to the first meeting. Those counties who have had the best success in engaging all sectors in their process were those that reached out to individuals by phone to invite them to be a part of the process. Sending a group email to a large number of people that have never worked together before or have never met is not going to get the same participation results.

What commitment should I expect from the partners?

Another key to engaging partners is to share with them up front what the commitment will be. In the 40+ counties we work in, the CHA committee members know they will meet 3 times: an initial meeting to choose questions, another meeting to go over the rough draft of the report, and the final community event to release the data to the entire county. They know they will not be asked to provide additional data, to survey at the fair, etc. They are told the process takes 7-9 months from start to finish and those timelines are kept. In the 25+ counties where we facilitate CHIP processes, the committee members know we will meet 4 times, with the draft report being presented at the 4th meeting. The process will take 3 months. It is important to make the process as simple and easy as possible and to stick to the original timeframes that were promised so they want to come back. An efficient and streamlined CHIP process helps to maintain a spirit of collaboration and avoid burn out and resentment toward the convening agency.

How do I get my hospital on board and what if we are on a different cycle?

The following challenges can be overcome to work closely with your hospital(s):

- If a hospital system covers multiple counties and each of those county health departments is using a different methodology and different indicators, then the hospital system will likely not be able to collaborate to the extent that the county health department and state would like them to.
- Although hospitals determine their “service area” for their CHA, they can still participate at the county level. Reports can be generated to provide hospitals with primary and secondary service area data if all counties were using the same methods and indicators.
- Most hospitals chose to submit their first CHA and implementation plan to the IRS in 2013. However, some hospitals are on a different cycle and may have submitted earlier. This should not be a barrier since hospitals are not required to submit primary data from the year they submit. So if a county did a CHA in 2015 and there were multiple hospitals in that county on different cycles,

each of them could post it to their website when needed to meet IRS requirements. So one hospital might need to post it by June 2015 and another by December 2016. The IRS “counts it” as complete on the date it is posted to the website.

- Keep in mind that hospitals do not have the same fiscal years as all state agencies have, so hospitals could have fiscal years ending in February, April, December, or anything in between.
- If you have never met your hospital CEO, schedule a meeting to meet with them prior to this process ever starting.

Who should convene the committee and who should facilitate the processes?

In most counties, the health department convenes the committee. However, it should not matter who convenes, signs the contract, or collects the funding. Be sure this does not hinder the process.

Most counties in Ohio choose to hire an outside facilitator to complete their CHAs and/or CHIPs. This is important so the community does not view the CHA as a “health department report” or a “hospital report”. This also removes bias within the process and report. When choosing a facilitator and/or vendor, be sure they are following a standardized approach and indicators and they also align the local work with the state SHA and SHIP. When at all possible, collaborate with other counties in your region to use the same facilitator for reasons stated earlier.

Who are the typical funders and at what level?

In most counties with which HCNO has worked, the following are the typical funding sources for the CHA:

- Health Department (35% of total cost)
- Hospital (35%)
- Behavioral health board (mental health board/ADAMH) (10%)
- Other agencies – United Way, JFS, FQHC, FCFC, Board of DD, etc. (remaining 20%)

However, some counties have up to 22 funders. Alternatively, some counties have 1-2 large funders because they were fortunate to receive a grant or foundation funding. Due to the behavioral health boards (mental health/ADAMH) and FQHCs also needing this data, it might make more sense for funding to be closer the following:

- Health Department (25% of total cost)
- Hospital (25%)
- Behavioral health board (mental health board/ADAMH) (20%)
- FQHC (20%)
- Other agencies – United Way, JFS, FCFC, etc. (remaining 10%)

Sandusky County Health Partners have the strongest, most sustainable funding strategy. The Health Partners contribute “dues” on an annual basis so that every 3 years they have money sitting in the “pot” to pay for the assessment. The larger organizations pay up to \$5,000 per year and some organizations pay as little as \$500 per year.

In summary, the following factors will lead to successful collaboration:

- Convening at the county level
- Having all of the sectors at the table
- Using a standardized process and set of indicators
- Using a neutral facilitator
- Sticking to a timeline and work plan