2016 BUILDING ACTION COLLABORATIVES FOR HEALTH IMPROVEMENT

Three regional cross-sector stakeholder meetings in Minnesota to promote action-oriented collaboration toward population health improvement

Summary of Project Activities and Participant Input

Project Summary

Background

This project was a collaborative initiative to host three regional stakeholder meetings in May and June 2016 to determine areas for action-oriented collaboration around community health assessments. The project was funded in part by a $4,900 County Health Rankings and Roadmaps grant, with the Minnesota Local Public Health Association (LPHA) serving as project lead. A project planning committee developed the goals and structure for completing the work.

Activities and Partners

The project planning committee membership included cross-sector representation: Minnesota Local Public Health Association (LPHA); Minnesota Hospital Association (MHA); Minnesota Council of Health Plans (MCHP); Minnesota Department of Health (MDH); and representatives from local health departments and county-sponsored health plans. The planning committee hosted three regional events, inviting a mix of stakeholders to participate. Planning committee members sent event announcements and registration links to their respective organization networks the first week in May. Committee members monitored registration lists and made follow-up contact with missing stakeholders to the extent possible.

Three regional meetings were held, with the following attendance:

1. **Metro Region**, 33 participants
   Minnesota Counties Intergovernmental Trust (MCIT)
2. **St. Cloud**, 29 participants
   Best Western Plus Kelley Inn – Conference Center
3. **Mankato**, 29 participants
   Country Inn and Suites by Carlson – Conference Center
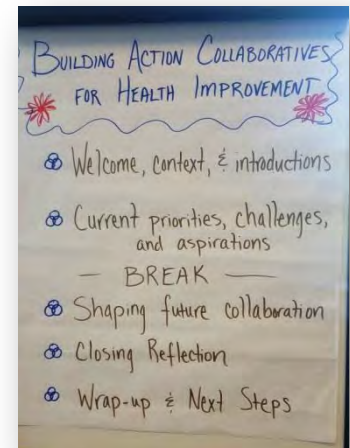
Project Outcomes

- Participants were activated by the opportunity to discuss shared challenges and aspirations with regional partners
- Leaders from each sector collectively identified needed tools, resources, and technical assistance to advance health together
- Participants expressed their own commitment to engage regularly in sharing resources, best practices, and models that work with community partners
- Planning committee members – state-level leaders from each sector – renewed engagement with each other and will use project results to steer upcoming fiscal and grant writing priorities, focusing on improving technical assistance and sharing of best practices among CHA/CHNA partners

What Participants Said

Current priorities, challenges, and aspirations
Themes emerged in this discussion across sectors and regions

- Existing cross-sector collaboration is strong, and there is more work to do;
- Implementation is challenging, especially determining how to share the work;
- Data is a concern for all – procurement, design of qualitative and primary data collection, especially from diverse populations;
- Stakeholders expressed strong desire to learn more about best practices and helpful tools for assessment and planning work;
- Health equity is an emerging concern, but more work is needed, especially in: refining shared terminology and data definitions; setting priorities; building agency capacity; and determining how to responsibly capture input from diverse populations.
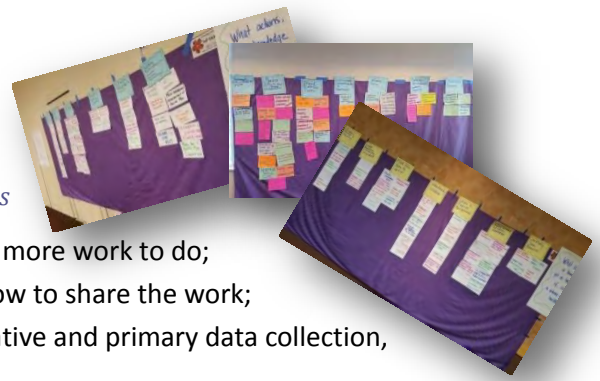
Shaping future collaboration
Themes of responses: What actions/partners/knowledge will help us get to the next level of collaboration to achieve community health improvement?

- Partnerships/ Collaboration
- Taking Action
- Structure/ Process
- Equity and Inclusion
- Sharing Data & Resources
- Regulatory Requirements
- Sharing Best Practices

Desired next steps
Participants concluded the brainstorming session, answering the question: What actions will we take to keep the momentum going?

- Distribute summaries of input from these three meetings;
- Share a comprehensive list of CHA/CHNA points of contact across the region, across the state;
- Explore ways to address the challenge of different regulatory requirements for CHA/CHNA;
- Reach out, better include health plans;
- Share best practices via webinars, in-person training, or online community of practice;
- Conduct regional trainings on identified needs; and
- Be inspired to foster intentional relationships with collaborative partners.

Feedback
Comments on event evaluation forms

- "Refreshing to talk with other key leaders of CHA/CHNA (MDH, LPH, Hospitals, Health Plans) about the challenges we are all facing beyond the regional data group level"
- "More tangible, specific tools to address the barriers identified and tools known for success would be helpful"
- "Awesome to see MDH & MHA - local & state in the same room! Great collaboration!!"

Evaluation

Participants completed event evaluation forms at the conclusion of each event. Results and select participant comments are included here.

The event met the following objectives…	% Strongly Agree/ Agree			
	Metro (5/20)	St. Cloud (5/24)	Mankato (6/1)	Combined
Build upon and strengthen local/regional collaborative relationships	90	73	73	**78**
Share resources and current/best practices in completing Community Health Needs Assessments (CHA/CHNA)	65	73	69	**68**
Discuss existing successes and barriers	95	95	96	**96**
Identify opportunities for action-oriented collaboration in local planning efforts	90	91	81	**84**
The topics covered were relevant to me	95	100	92	**96**
The event enhanced my knowledge and/or skills in the topic area	85	86	77	**82**
I will be able to apply the knowledge/skills gained from this event to my work	90	82	77	**82**

Desired Resources and Additional Feedback

What additional resources, tools, or technical assistance would help you improve your process and/or collaboration toward completing the Community Health Needs Assessment (CHA/CHNA)?

- More tangible, specific tools to address the barriers identified and tools known for success would be helpful
- Could MDH have a CHA/CHIP communication team that could help us w/data storytelling (as you have for the SHIP grant)?
- Webinars - to build skills - MAPP, Take Action Cycle, or other tools for CHNA/CHA; Data analysis; Joint planning
- Data assistance - identifying relevant data and experts to analyze survey results and needs prioritization
- Discussed today best practice guidelines, resources, contact people in each county

Provide any additional feedback here

- Tommi & Sarah did a great job w/the interactive exercise. I am very touched that the group process resulted in answer to the original question - that is so cool.
- I don't think it was clear what the purpose of the meeting was. I thought it would be work with partners on developing our plan.
- Sent out agenda did not reflect what I expected happen in the meeting. I assumed we will hear more about best practices, case studies, earn about new tools
- Refreshing to talk with other key leaders of CHA/CHNA (MDH, LPH, Hospitals, Health Plans) about the challenges we are all facing beyond the regional data group level
- Awesome to see MDH & MHA - local & state in the same room! Great collaboration!

Planning committee members

Name	Title	Organization	Email
Carol Biren	Division Director – Public Health/ CHS Administrator	Southwest Health and Human Services	carol.biren@swmhhs.com
Ann Challes	Women & Children Care Coordinator	PrimeWest	ann.challes@primewest.org
Ashlyn Christianson	Public Health Manager, Government Market Solutions	Blue Cross and Blue Shield of Minnesota	ashlyn.christianson@bluecrossmn.com
Allie Freidrichs	Director	Meeker-McLeod-Sibley Community Health Services	allie.freidrichs@co.mcleod.mn.us
Tommi Godwin	Planner	Washington County Department of Public Health & Environment	tommi.godwin@co.washington.mn.us
Lowell Johnson	Public Health Director	Washington County Department of Public Health & Environment	lowell.johnson@co.washington.mn.us
Kristin Loncorich	Director, State Government Relations	Minnesota Hospital Association	kloncorich@mnhospitals.org
Lorna Schmidt	Director	MN Local Public Health Association	lschmidt@mncounties.org
Sarah Small	Principal Planner	MDH – Health Partnerships Division	sarah.small@state.mn.us

World Café Input: Current priorities, challenges, and aspirations

Event participants first discussed current priorities, challenges, and successes in a *World Café* style discussion, wherein they rotated through three hosted topics, each round building upon previous input. Key themes by regional group are summarized here.

	Partnership and Community Engagement	Strengths and Successes	Challenges and Barriers	Health Equity
Metro Region 5-20-2016	- Center for Community Health (CCH) a driving force in Metro Region - New requirements have driven partnerships - Some data sharing happening (EHR data with LPH, Schools with various partners) - Differences in defining "community" and/or "population health" - Missing: Human services, philanthropy, funders,	-CCH is an asset - Strong public health system(s), infrastructure, and pattern of resource sharing - Established shared data indicator framework - The right people are at the table - Data sharing is a priority - "In this together" - strong collaborations and technical assistance work	-Differing timelines and requirements - Missing good sources for local, neighborhood, and diverse population data - Differences in defining "community" and/or "population health" - Trust is an issue (from residents, among partners) - Process is highly resource-heavy - Shared implementation is difficult	-Work has begun in keeping HE as agency priority and attempting to hear from high-need populations - Challenges: HE analysis can be slow, inconsistent definitions from agency to agency, inherent conflict between health equity and business/profitability - Assets: priority exists to build staff capacity

	Partnership and Community Engagement	Strengths and Successes	Challenges and Barriers	Health Equity
St. Cloud 5-24-2016	- Established pattern of partnerships between local public health and hospitals - Good current partnerships with community organizations - Recent requirements have "forced" partnerships, which have stuck and benefit all - Collaboration challenged by several factors such as staff turnover, multiple agencies on differing timelines, difficulty securing sustainable funding	- 16-County collaboration on health survey - Shared ownership and value for the work, picking up momentum and becoming meaningful after several rounds - External partnerships help with data and survey work (e.g. MDH Center for Health Statistics)	- Complexities involving data: collection is costly; a lot of available data, too much to interpret meaningfully; difficulty capturing qualitative health equity data - Organizational structures, specifically multi-county CHBs partnering with various/multiple health systems - Changing leaderships structures	- Several new ideas about how/where to reach special populations - Qualitative data is important but low skills to gather it - Health Equity is so big, collaboration is essential
Mankato 6-1-2016	- Strong current collaboration between hospitals and public health - Level of collaboration varies by hospital/ system - Joint ownership of assessment makes implementation challenging - Missing - health plans	- Strong MDH support and good community partnerships (faith communities, schools, businesses, etc.) - SHIP provides a means for building partnerships - Partnership above and beyond CHA/CHIP, e.g. food access	- Moving from assessment to action is difficult - Securing sustainable funding for the work - Organizational structure and staff capacity, especially competing health dept demands of CHA/CHIP vs service delivery	- Good existing momentum, growing work in assessing/understanding health equity (SHIP-funded Spanish survey, IDI training, workforce development) - More work remains - reaching the right people, data analysis and visualization

METRO REGION – MAY 20

Partnership and Community Engagement

What does partnership between LPH, Hospitals, and Health Plans look like in your area? What does partnership with the community look like in your area? Who is at the table?

- New partnerships that are outside typical county-Hospitals not located in a county but patients come from that county – so need to partner with LPH
- Metro – come together for diverse community engagement for input
- Statewide – not sure there was much of a relationship between LPH and hospitals. CHNA hospital requirements have helped push/develop those relationships. More work needs to be done.
- Hospital/PH data sharing with Hennepin Co
- How to define community: hospitals look at where patients come from. Patient zip code probably.
- New IRS law directed energy and collaboration
- Expanding sense of community
  - From geographic borders
  - To people who "live, work or play" in the county
- More awareness to get good representation from a cross section of the community
- Multi-pronged collaborative approach to get input from special populations and then circle back from assessment to these groups to find solutions
- Some historical relationships between LPH and Hospitals have been great – but "new" systems and new relationships are needed

- CCH is focal pt. of hosp/health plans/LPH efforts in assessments (2)
- LPH still primarily looks at geographic boundaries – but these collaborative projects are challenging those assumptions
- Exchange of clinic/hospital data with schools
- Group of community agencies – PH, community health
- Small groups – discussion – get diverse points of view
- Define community, depends on where you sit
- Not as good as would like – mental health
- So many opportunities that could be more aligned, strengthen opportunities to + impact
- Need to convene community engagement meetings together! – Hospitals/Health Plans/LPH's – cannot
- Schools
- Local government
- Nonprofits
- Business, private orgs
- Faith communities

Who is missing from the table in your CHA/CHNA process?

- Human services (county, state)
- Philanthropy
- Funders
- Collaboration in requests – health care, payors
- Pop health vs. public health
- Alignment of CNA efforts – efficient
- Human services missing

Strengths and Successes

What are your regions strengths and assets in this work?

What helped improve/advance CHA/CHIP/CHNA work in your region?

What is going well in your region around CHA/CHIP/CHNA?

- Doing work for long-term
- Followed the MDH outline
- Did community survey, 3000 people responded – tapped into diversity
- Community health integration specialist – paid for by 5 organizations (public health, United Way, local area foundations)
- Coalition for community health
- Agreed upon list of inidicators
- Have the right people at the table
- Formed work group for each indicator
- Community listening sessions
- Public Health, Olmstead, and Mayo
- Data subgroup
- Willing to share resources

- Statewide partnerships and # of organizations
- Missing health plan @ the table in other states
- Nonprofit status helps
- Grass roots efforts
- Own the process – authentic
- Leadership at MDH – especially re: health equity
- Technical assistance from local counties
- Aligning work, community resources
- "In this together" – most don't have resources
- Continuous improvement cycle
- IFT assigned to CHA/CHNA, structure of workgroups
- Community listening sessions
- Partners have in-kind engagement
- Expertise of staff in planning/assessment process
- Data users group – regional

- Building networks based on community buy-in
- Minnesota Nice!
- Resources – community health consulting hired to help meet requirement
- Identify improvement for 'next round'
- PH – changed to 3-year cycle
- Priorities don't change
- Every 3 years not necessary
- Get community partners/colleagues educated, esp. leadership
- Center for Community Health – created a network, data subgroup for 2nd round of CHIP
- CCH steering community assessment – real effort
- Long history since PH Act – not new
- Understanding requirements/ to build partnerships
- State has aligned with PHAB requirements
- Doing similar work @ hospitals and PH
- Know contacts
- Great facilitators
- Follow MDH guidelines – Part I and Part II
- Resources available last time – community survey
- Difficult across state line (WI)
- Strong public health system
- Strong infrastructure
- Longstanding relationships
- Center for Community Health – Collaboration between 3 sectors – hospitals, health plans, public health
- Collective action around mental health
- Strong relationship and network building

Challenges and barriers

What are the challenges in sharing data with partners? What are challenges to doing data collection and analysis in partnership?

What are the greatest struggles around CHA/CHIP/CHNAs specific to your region? Why?

What would you do differently in the future based on the challenges and barriers we've discussed here today?

- Need neighborhood level data
- Solution: shared set of data elements
- Community input – aren't represented well
- Health indicators don't represent diverse community
- Timing regulations: Reg to work with LPH but not on the same schedule
- Changes in requirements
- Lack of resources
- Hard to get quantitative data on localized populations
- Pockets of poverty in affluent areas – easy to lose issues
- Not getting data on those with most needs
- CCH is working well
- Align timing – state and fed – a good solution
- We just tried to get it done
- Complexity
- Cycles of time
- Miss pockets of need
- Community engagement

What are the organizational-level challenges in your work? Partner level? Community-level?

- Skill development and training for community engagement – culturally and technically
- Trust is an issue for all of us w/citizens
- What can we as a hosp do to support social determinants of health – transportation, housing?
- How do we contribute to improving outcomes?
- Many of these efforts are not reimbursable
- Specialty hospitals – how to do this usefully for our niche
- Resources – took 17 people statut. req to provide data
- Expensive to do this
- Evaluation takes time
- Multiple hospitals in county
- Duplicate efforts highly frustrating; differing timelines and requirements
- Not useful info for us
- Hospital needs to show improvement starting next cycle
- We define community differently
  - Hosp: patients served
  - LPH: county lines
  - Barriers = diff to share useful info
- Payer pop: our insured in a county we serve
- For CCH – working toward common data elements
- Challenge to get the voice of the community
- Trust is at a low
- We collect all this info and then don't use resources to do anything about it
- Reaching the populations in need is difficult – outreach
- How to engage community partner – such as social services
- Data – one more request that doesn't align with other reporting
- Methods for data collection aren't working
- Smaller-scale data collection efforts would be more useful
- Can't keep going back to the same pop groups to ask the same questions
- EHR data aren't clear
- Want to ACT on the plan

Innovative local efforts and future aspirations

How can collaborating innovatively in your region help streamline the CHA/CHNA process for all? What innovative approaches to assessment and planning have worked for you?

- Channel energy: resources -> share best practices and common learning
- Sharing resources – sharing project coordinator
- Statewide system better than BRFSS
- Fill in data gaps from rankings (CHR)
- Assessment -> Implement – use existing CHNA to inform priorities that will stay
- Use of existing research team with community outreach expertise to gather authentic report

- Coordination – streamline – share community input – tell hospital then tell PH
- Same populations being over-surveyed
- Assessment Alignment (CCH) sub-committee

Moving forward and dreaming big, what aspirations do you have for future CHA/CHNA work in your region? The state?

Let go of perfection
- Same timeline
- Center for Community Health Assessment Alignment Sub Committee
- Initiation of ongoing conversation with community vs. 1x input – constant conversation about health
- Social Connectedness – Revelation as a critical health indicator among culturally diverse groups
- Using college students to extend demographic representation among millenials
- Expanded involvement across org. in CHNA engagement work – put CEOs in a room
- Top leadership involvement and use of results for decision-making

- Alternative to land-line phone surveying
- Community model and business model link
- Jointly paid staff for collective activities
- Shared data set, foundational group of indicators
- Data + storytelling -> motivation
- Visual – accessible presentation of data
- Move from data to collective action
- Structured question for mental health – same question/same way
- Collaboration of the collaboratives – how many collaboratives do we need?
- Use of students – have projects ready for students – ongoing relationships with schools for continuous flow
- Inclusion of social connectedness and resilience

Health equity

What has your agency done to bring a health equity lens to CHA/CHNA work? What resources, tools, or technical assistance has helped you better incorporate a health equity frame into your work? How can collaboration and partnership further health equity efforts in community health assessment?

- Priority work groups
- Share strategies with groups to get input
- Go back to community
- Social risk factors
- Program design

- Dashboard – start with few metrics
- Privacy challenges
- Neighborhood integration program
- Info sharing
- New priorities – deeper dive

- HE Analysis Slow
- Services available to all
- Survey through health equity lens
- Focus 1st on 10 disparities
- Community listening sessions vs focus groups to inform CHNA – return for more input
- Build relationships woven throughout
- How are we doing?
- Rochester epidemiology project – prevalence
- MN Community Measures
- Zip code hot spots – example: highest BMI then by other demographics (3D map)
- Access as it relates to access
- Definitions are inconsistent, can't cross-compare across sectors; no one is partnering w/universities
- Know what makes largest impact legislatively
- Listen to community experiences

- Mission-related
- UROC
- Counties have different health inequities – leads into separate definitions
- Guild internal capacity to understand health equity
- Equity – different within region
- Work on breaking silos – internally and externally
- Building capacity
- Community issue
- Health Disparities Office within the clinic
- Health Equity is a complex issue
- How do we move forward when we have a business model
- Make community dialogue equitable
- Make opportunities available to invite people to community dialogue

ST. CLOUD – MAY 24

Partnership and Community Engagement

- Understanding goals of all agencies -> findings, strategies, for common goals
- Longer history of partnership betw LPH and Hospitals, not plans
- Challenge:
  - multiple hospitals/clinics in PH's area (or vice versa)
  - Staff changes; new staff at hospital to do CHNA – used to be a communication/marketing responsibility
  - Networking is challenging
- Success – doing survey in partnership across sectors
- Driven by $ – without SHIP $, may not have obesity focus
- Struggling to find continuing $ – focus on grant writing and financial partnerships
- Health equity – building community capacity, better focus on community's wants and needs
- Community = geographic or underserved populations, youth, seniors
- Cross Sectors – partnering on community engagement regardless of 3-year/5-year barrier
- Who is at the table?
  - County commissioners, community, PH, health plans, hospitals, community organizations

- Community benefit advisory council used – business, LPH, MH – updates from everyone; shared resources; everyone has a voice
- Community forums -> help identify who is missing
- Online survey – top people who serve target populations
- Partnership lack w/ health plans
- Good partnerships w/community groups
- New CHB Building relationship
- Hospital footprints – growing systems purchase small hospitals
- Last 5 years strong partnerships w/hospitals and local public health
- Preparedness planning (state $ "forced" partnerships)
- Next 5 years
  - Where are the overlaps
  - LPH WIC clinic in Hospital/Clinic?
  - County financial worker into clinic/hospital, to get folks enrolled in public programs
- Quarterly community benefit meeting @ hospital bringing in LPH leadership encourages partnerships
- Becoming the norm to be at each other's meetings
- Collaborate to create community health survey
- Shared data in format partners want
- Access to CHIP, shared plan
- LPH presented CHIP to hospital leadership

- Hospital used LPH tobacco data to go into EMR to see if same result
- Who is missing?
  - Tribes?

  - Faith based communities
  - Minority communities
- Resources
  - CBP have brought groups together – good resource

Strengths and Successes

- 16-county cooperation – survey & $
- SW/SC data group foundation of survey
- Funding from SHIP
- MDH – Data Resource (Ann and Kim)
- Wilder – info, tools, graphs, summaries, etc.
- Outside partnerships – for a deeper look into parameters and surveys
- Familiar process – multiple rounds – experience
- The Community is defining health
- Not just the responsibility of PH or Hospitals
- Becoming meaningful – conversation dialogues
- Not typical partnerships
- Created a framework on paper – accountable

- Robust real time data PH survey Hospital funding
- Entities are working together – not apart
- Identified interested stakeholders – groups/connections grow
- Small communities know each other, easier to partner – but who are we missing?
- PH gets it, now to tap into expert
- Doesn't matter who gets the credit, this is important work
- SWIF – social development added different view/focus
- Reservation health surveys
- School health survey
- Meeting people where they are to collect data
- Bars, parks, bail bonds, Walmart, etc.

Challenges and Barriers

- Different agendas, different framing -> leads to different responses
- Capturing all voices (public) in discussions: minorities, immigrant, refugee pops
- Multi-county CHBs working w/multiple hospitals
- Data is old
- 3 years too short
- Data collection is $$

- Shared funding to support partnerships
- Stats and public survey don't always align
- Challenging to ask for public input if you may not follow through with their suggestions
- Assumption that all hospitals are for-profit
- Everything starts with collaborations in the community (joint meetings, joint requests)

- Not all hospitals are required to participate (and not all want to)
- Some schools don't participate in state student surveys
- Different agendas mean there isn't always a natural leader
- Politics of personalities
- A lot of data but is it always interpreted/ analyzed correctly?
- How to share data w/community? Not user-friendly
- Contracts for work don't always produce a useful product – is anyone satisfied with a contractor? Which ones?
- Some hospitals have agreed to use common set of core questions
- MDH is a valuable but limited resource (Ann Kinney)
- Staffing transitions, lack of time (esp. in smaller, rural areas)
- Changing leadership

- Different levels of commitment/ viewing CHA/CHNA as priority
- Not as good when no done together – goes back to different timelines
- Vastness and complexity of data and how it's presented
- Still understanding "evidence based" and social determinants of health
- Different Questions – can this be streamlined? Best examples?
- Get stuck in the "move to action" phase
- "Bridge to Health" model – joint funding for survey
- Secret to keep task forces/ workgroups engaged and active?
- For each CHB or region – paid leadership to align activities and priorities across sectors – neutral entity

Health Equity

- Oversampling and convenience sampling in populations with poorest outcomes
- Focus groups in same populations
- Benchmark of population is 30 for surveys
- Intentional learning about health inequities from the people most impacted
- Qualitative data is important but we don't know how to gather it
  - Use MDH staff from office of Health Statistics
- SHIP H.E. assessment being piloted

- Engage professionals/ providers from communities experiencing inequities (key informants) and help with solutions
- American Indian Health Fair
- Focus groups in established groups of cultural diversity
- Pulled in Fon du Lac Survey and they joined prioritization planning
- Have diverse groups and underserve at the table
- Have members define their health needs – use social determinants of health
- Pledge to address Health Inequity
- Diversity, disparity is more coupled

- Multi-sector – park and rec, housing
- Contracted to do focus groups & key informant interviews
- Need to learn more about how to reach different populations
- Go where low income people gather e.g. WIC, food shelves, etc.
- Be in the community and listen – relationships
- Look deeper at the data
- Addressing health equity is so big collaboration is essential
- Partnerships with agencies that serve underserved populations
- City planning
- County commissioners – invite to hospital table
- Hire staff (CHW) from communities – Somali, Hmong

MANKATO – JUNE 1

Partnership and Community Engagement

- Survey work
- Missing piece – health plans
- Evolving hopefully to collaboration
- Offer open stakeholder meetings
- Be involved from the beginning
- Consensus based decisions and priorities
- Requirements/deliverables guide decisions
- Health plans – missing – we don't know why – do they focus on their customers? Do they focus on biggest bang for the buck? Diverse populations – health equity
- Resources – MAPP, How do we put it into Action? Where's the Data?
- Collaborative true partnership for entire process
- SHIP refunded!
- New/different people – roles
- Need/challenge in engaging diverse population groups
- More true collaboration – ongoing work
- Crossing county lines, hospital catchment areas, insurance coverage
- Balancing grass tops with grass roots
- Community meeting to prioritize action/focus
- Consistent communication w/all partners
- With joint ownership who decides on Work Plan?
- Large entities hard to fit community focus work

- Strong connections within communities
- Collaboration will be required to make strong changes in communities
- Identify community partners "not usually" considered – definition of community expanding
- Using existing collaboratives or groups to get information – i.e. SHIP CLT
- Keep all collaboratives involves regardless of $$
- Focus groups add depth to survey data
- Community mapping – identify areas of highest need/ barriers/ resources
- Combined planning/needs assessment
- Not well defined/ community assessment varied
- Not doing good job including health plans
- Community priorities dependent on who is around the table
- With different health systems partnership is more difficult
- Focused engagement – more community partners around the table
- All hospitals and partners in one joint think tank
- Hospitals and PH work well together
- Colleges – free community clinic
- No health plans involved – helpful to add this
- Medelia based collaborative
- Analyzed by zip codes to give hospitals good information

- Be more involved with planning of survey up front
- Helpful for Health Plans to be at the table
- Community – input from the community
  - Difficult to engage general community members – need to figure out how to set attainable visions
  - Growing up healthy – BCBS grant
- Relationship with hospitals for survey/ not health plans
- Mayo varies on level of partnership
- Lack of collaboration/ different health systems vary
- Hospital desire to collaborate but finds it challenging

- Compressed cycle leads to challenges with strategy
- More collaboration
- Lining up cycles of survey, Timelines to be same
- Confusion with some community partners about why at table – focusing on relationships
- Carrying current partner relationships to new purpose
- Common purpose/ goal/ vision for group
- Community leadership team
- Partner on initiatives
- Definition of community varies

Strengths and Successes

- MDH support
- Community Partnerships – faith partners, colleges, schools, businesses, chamber of commerce, nursing homes, law enforcement, city officials
- Relationship building
- More internal alignment on priorities
- Spread collaborative and improvement work
- Gain in efficiencies
- Trust and shared goals and partnerships
- Accessible leaders/ decision makers are key – staff & financial resources

- Community ownership and buy-in and commitment moves work forward
- Being intentional about partnering above and beyond traditional CHA/CHIP -> e.g. food access
- Having key partners visible in the community
- Have hospitals and PH at the table – learn to speak the same language -> works toward shared goals
- SHIP – vehicle for building relationships
- EP – who is in each other's plans? Knowing who to call
- Older adult/ dementia -> community partners may see their role in this work more clearly
- Mental health first aid training – easy to involve partners

Challenges and Barriers

- Implementation of the CHIP – move to action is difficult
- Shared goals – difficult to agree
- Shared funding – difficult to achieve
- Grant requirements – sometimes set limitations
- Shared communications – expensive/ tough to be effective
- Shared dashboard
- Getting data RE: emerging issues – difficult
- Structural limitations: scope of assessment –keeping it manageable
- Struggle to balance assessment and take action (data paralysis)
- Huge issues/priorities – action?
- Timeliness – 3, 4, 5 years
- Multi-county challenges – multiple hospitals with different timelines
- Changing leaders – and varying engagement of leaders

- Hospital not required to do an assessment
- $$ - we have good collaboration but where's the funding?
- We need other partners at the table that have buy-in – the right partner, the right data
- Faith communities are missing
- Forming trust
- Collaboration takes time – every 3 years comes up fast
- Technical structure to make it all happen – "how to"
- Time and staff capacity –service delivery vs planning
- Lack of educators and planners inernally
- County level data is difficult to get – EHR is not = to population health data
- How to get data from non-traditional sources?
- Working in silos
- Ongoing funding for long-term action/ partnerships
- Hearing the voices (data) of unrepresented populations

Health Equity

- Spanish survey group – through SHIP hired interpreters
- Am. Hospital Association – Health Equity Pledge (1-2-3- for Equity)
- Spanish survey (shortened) & small group of full survey
- FP forms and UC binder done in Spanish
- SHIP survey – Elderly
- Resources – SCHA Interpreters
  - MDH Health Equity Toolkit (?) – to be piloted
  - Community leaders (i.e. Faith Community)
- Data analysis by demographics

- Focus groups, listening groups – targeted
- U of MN Extension – IDI training
- Health Equity Care Guides – staff clinics with clients with health disparities & diversity – internal interviews with the staff
- CHW – video to gather qualitative data about access to health care
- Pick a project – start acting – less questions
- Listening sessions to hear from missing voices from community survey – integrating quotes

- Disparity infographics
- Staff education
- Workforce development plan – intentional diversity
- Health equity case studies – engaging new voices
- Learning how to host focus groups
- MDH resources/ training
- Health Equity Toolkit
- Islamic Centers
- Getting the right/new voices at the table
- Avoid "parachuting"

- Using connections to elevate the community voice (e.g. Regional Transportation Discussions)
- Establishing mutually beneficial relationships
- How to talk about health equity (Tacoma – Pierce County – Washington)

Consensus Workshop Input: Shaping future collaboration

The second half of each event was spent brainstorming action items to improve future collaboration. Attendees participated with a *Consensus Workshop,* a Technology of Participation (ToP) facilitation format, generating many similar responses across the state, though some regional nuance emerged.

Detailed consensus workshop results are included on the following pages. Here are the category titles from each of the three sessions.
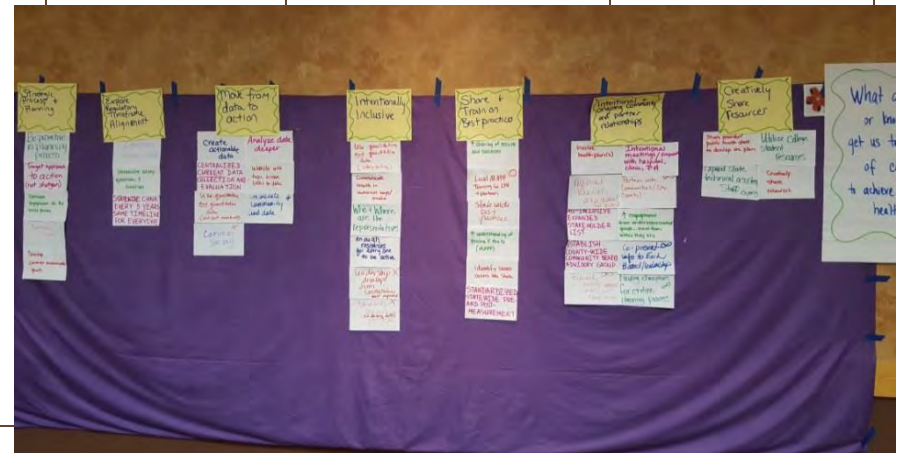
What actions/partners/knowledge will help us get to the next level of collaboration to achieve community health improvement?							
	Partnerships/ Collaboration	**Taking Action**	**Structure/ Process**	**Equity and Inclusion**	**Share Data & Resources**	**Regulatory Requirements**	**Best Practices, Communication**
Metro Region	Maximize efforts through diverse collaboration	Pick a needle to move	Standardize Process	Authentic Non-Duplicative Community Engagement	Shared accessible data	Influence Policy	Coordinated Communication and Outreach
St. Cloud	Intentional and ongoing community and partner relationships	Move from Data to Action	Strategic Process and Planning	Intentionally Inclusive	Creatively Share Resources	Explore Regulatory Timeframe Alignment	Share and Train on Best Practices
Mankato	Building Relationships to Foster Strong Partnerships	Taking Action and Getting Results	Defining a Coordinated Process	Use a Health Equity Lens	Developing and Identifying Resources		Increasing Knowledge and Skills

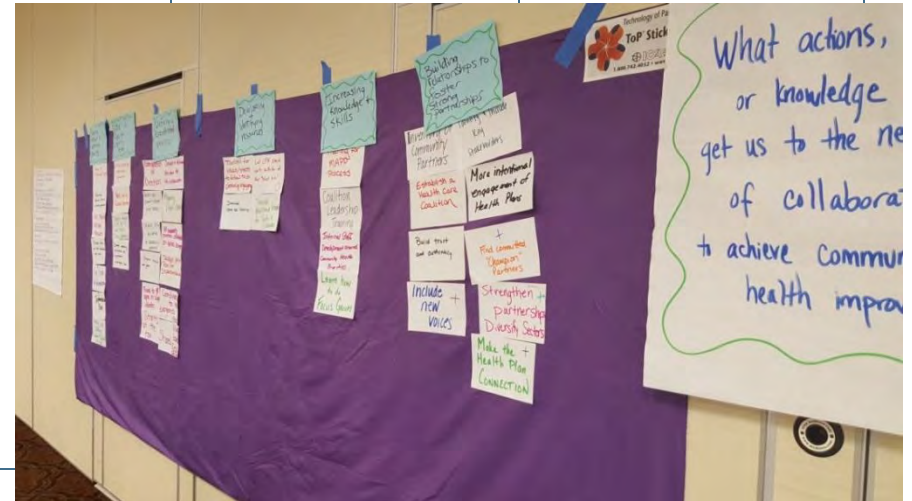| What actions/partners/knowledge will help us get to the next level of collaboration to achieve community health improvement?						
Maximize efforts through diverse collaboration	**Shared accessible data**	**Pick a needle to move**	**Coordinated Communication and Outreach**	**Influence Policy**	**Authentic Non-Duplicative Community Engagement**	**Standardize Process**
Create a shared vision	Central data hub	Common health priorities with a unique neighborhood approach	"Health on a stick" – state fair presence	Timeliness for assessments be aligned (policy change)	Community engagement (emphasis on residents not organiz.)	Collaborative data collection from special populations
Better defined collaboration/ partnership structure	Technology to share data		"Champion" tells our story	Change IRS 3-yr requirement for hospitals	Common community conversations through unique relationships	Common definitions of key indicators for data sharing
Combine work and share resources	Asset mapping/ inventory	Collective action on one health priority statewide		Policy maker buy-in	Inclusive, representative community engagement and involvement	Standardized CHA/CHIP Template/Process
Collective approach for new resources	More sharing and coordinating data	Implementation of evidence based practices		Ensure education of all policy makers on these requirements	Combine strategies for community engagement	Standardized EHR data format
Convene alike groups (e.g. hospitals) then diverse groups	Common measurement (monitoring and evaluation CHIP)	Larger focus on fewer efforts (evidence-based)		Permission from organizational leaders (state, federal gov) to partner (waiver)		
Peer colleague network	Access to resources for shared data analytics					
Get the word out on Olmstead's model (or a similar model)	Develop a data repository for the shared data					
Joint pot of money for dedicated staff to do CHS	Collaboration and data simplification					
Joint infrastructure to ensure action	Create shared database					
Sustainable shared staff for collaboratives						
Greater leadership commitment and engagement						
Diverse skill sets						
Diverse groups of community partners						
Get business sector involved						

What actions/partners/knowledge will help us get to the next level of collaboration to achieve community health improvement?						
Intentional and ongoing community and partner relationships	**Intentionally Inclusive**	**Move from Data to Action**	**Share and Train on Best Practices**	**Strategic Process and Planning**	**Creatively Share Resources**	**Explore Regulatory Timeframe Alignment**
Involve healthplans(s) Intentional meetings/frequent with hospital clinic, PH Regional health assessments (all sectors) Partner with communities (city, county) All-inclusive expanded stakeholder list Increase engagement from underrepresented groups… meet them where they are Establish county-wide community benefit advisory group Co-present info to each board/ leadership Quarterly meetings with all stakeholders Finding champions for entire planning process	Use qualitative and quantitative data (story telling) Communicate results in numerous ways/ media Who and where are the representatives Enough resources for everyone to be active Leadership develops from communities most impacted Community leaders participate (including faith leaders)	Create actionable data Analyze data deeper Centralized current data collection and evaluation Website with topic driven links to data Use qualitative and quantitative data (not just numbers) Consolidate community level data Common survey	Increase sharing of results and successes Local MAPP Training for LPH and Partners Statewide best practices Increase Understanding of process and tools (MAPP) Identify success across the state Standardized statewide pre- and post-measurement	Be proactive in planning process Target approach to action (not shotgun) Continued engagement for the entire process Common goals Develop common measurable goals	Share provider/ public health staff to develop one plan Utilize college student resources Expand state technical assistance staff capacity Creatively share resources	Common time frames Streamline survey questions and timelines Statewide CHNA every 5 years same timeline for everyone

MANKATO, MN – June 1, 2016

| What actions/partners/knowledge will help us get to the next level of collaboration to achieve community health improvement?					
Defining a Coordinated Process	**Building Relationships to Foster Strong Partnerships**	**Taking Action and Getting Results**	**Use a Health Equity Lens**	**Developing and Identifying Resources**	**Increasing Knowledge and Skills**
Coordination of direction	Inventory of community partners	Focus on actionable "nuggets"	Hire people from underserved populations	Toolkit for ideas/ steps to follow to do community engagement	Training for MAPP process
Develop a defined structure for the collaborative	Identify and include key stakeholders	Show some positive results in health improvement	Reach out to diverse populations	Let LPH staff work outside of their "grant silo"	Coalition Leadership Training
Broadly align community assessment survey timelines	Establish a health care coalition	Use tangible outcome measures	Identify partners not yet at the table (diverse populations and community members)	Dedicated staff and resources	Internal staff developed around community health priorities
Aligning CHA & CHNA	More intentional engagement of Health Plans	Increase action on social determinants – make a start		Technical assistance grants for tools to collaborate	Learn how to do focus groups
Ongoing face to face meetings for accountability/ relationships	Build trust and authenticity	Next steps for implementation	Deepen community involvement and engagement – mature beyond checkboxes		
All community partners collaborate on various surveys	Find committed "Champion" Partners	Implementation plans			
Shared timeline and goals	Include new voices	Clearly defining problem and related action			
Develop joint plan for implementation	Strengthen partnerships, diversify sectors				
Process to agree on scope/ indicators	Make the Health Plan Connection				
Coordination to meet everyone's needs					
Starts at the top					
Shared vision, goals, responsibilities, timeline					

THIS PAGE INTENTIONALLY BLANK

Building Action Collaboratives for Health Improvement

A focused discussion of community needs

Agenda – 12:00 to 4:00pm

- Welcome, context, and introductions
- Reflect on current priorities, challenges, and aspirations
- Break
- Shaping future collaboration
- Closing reflection and looking forward
- Wrap up and next steps
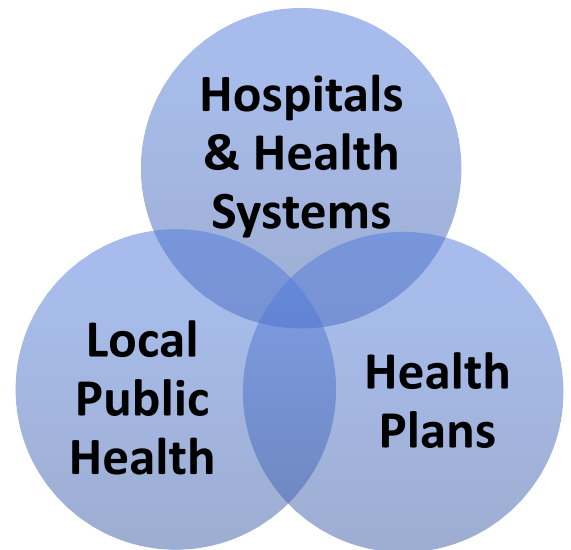
Glossary and Acronyms

CHA – Community Health Assessment, MN requirement for Local Public Health

CHNA – Community Health Needs Assessment, federal requirement for non-profit hospitals

CHIP – Community Health Improvement Plan, MN requirement for Local Public Health

MHA – Minnesota Hospital Association

LPH – Local Public Health

MCHP – Minnesota Council of Health Plans

MDH – Minnesota Department of Health

Collaboration Plan – MN requirement for health plans

Organized in Partnership by

Local Public Health Association of Minnesota
Meeker-McLeod-Sibley Public Health
Minnesota Council of Health Plans
Minnesota Department of Health
Minnesota Hospital Association
PrimeWest Health
Southwest Health and Human Services
Washington County Department of Public Health and Environment

Assessment and Planning Resources

General
County Health Rankings & Roadmaps – Learning and Resources, Taking Action

http://www.countyhealthrankings.org/roadmaps/action-center/assess-needs-resources/learning-and-resources
http://www.countyhealthrankings.org/roadmaps/action-center

Myths that Fuel Resistance to Public Health and Hospital Collaboration, Public Health Foundation:

http://www.phf.org/resourcestools/Documents/Myths_that_Fuel_Resistance_to_PH-HC_Collaboration.pdf

Mobilizing for Action through Planning and Partnerships

http://archived.naccho.org/topics/infrastructure/mapp/

Health Plans
Statute 62Q.075, Health Plan Collaboration Plan:

https://www.revisor.mn.gov/statutes?id=62Q.075&year=2015&keyword_type=all&keyword=6.075

Implementing Community Health Improvement Plans: Ways to Partner with Health Plans webinar:

http://mnhealthplans.org/improving-public-health/

Minnesota Council of Health Plans 2015-2019 Collaboration Plan:

http://mnhealthplans.org/wp-content/uploads/2014/12/2015-to-2019-Collaboration-Plan-FINAL-12292014.pdf

Public Health
Statute 145A.04, Local Public Health Act requirements:

https://www.revisor.mn.gov/statutes/?id=145A.04#stat.145A.04.1a

Statute 145A.131 Local Public Health Grant requirements:

https://www.revisor.mn.gov/statutes/?id=145A.131

LPH CHA Priorities 2010-2014 Cycle:

http://www.health.state.mn.us/divs/opi/pm/lphap/2010-2014/tenissues.html

LPH CHIP documents:

http://www.health.state.mn.us/divs/opi/pm/lphap/2010-2014/chip/

Hospitals
Minnesota Hospital Association: Preliminary report on health need in Minnesota hospitals' and health system's communities:
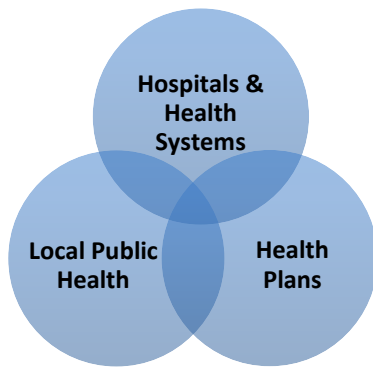
http://www.mnhospitals.org/Portals/0/Documents/data-reporting/CHNA/PreliminaryCHNAreport1-6-14.pdf

Minnesota hospitals' and health systems' highest priority community health needs:

http://www.mnhospitals.org/Portals/0/Documents/data-reporting/CHNA/CHNAspreadsheet.pdf

MHA CHNA Website:

http://www.mnhospitals.org/data-reporting/mandatory-reporting/community-health-needs-assessment

Community Health Assessment in Minnesota

The goal of a **community health assessment**[1] is to identify, quantify and describe **community health** issues and to characterize community assets that may help meet needs and improve health. In **Minnesota**, several community sectors engage in assessing a community's health. These sectors include, but are not limited to: **Health Plans**, **Non-Profit Hospitals/ Health Systems,** and **Public Health Agencies**.

HOW COMMUNITY HEALTH ASSESSMENT FITS INTO THE BIGGER PICTURE

Community Health Assessment is typically the first stage of a multi-step process which includes assessment, prioritizing, planning, implementation and evaluation. Improved **coordination** and **collaboration** between Minnesota's Health Plans, Hospitals-Health Systems and Public Health during the assessment, prioritization and planning stages will result in better use of community and organizational resources. The Centers for Disease Control and Prevention has described a similar desired state[2] for multiple stakeholders that unifies community health improvement efforts.

i. Assess → ii. Prioritize → iii. Plan → iv. Implement → v. Evaluate → **IMPROVED HEALTH OUTCOMES**
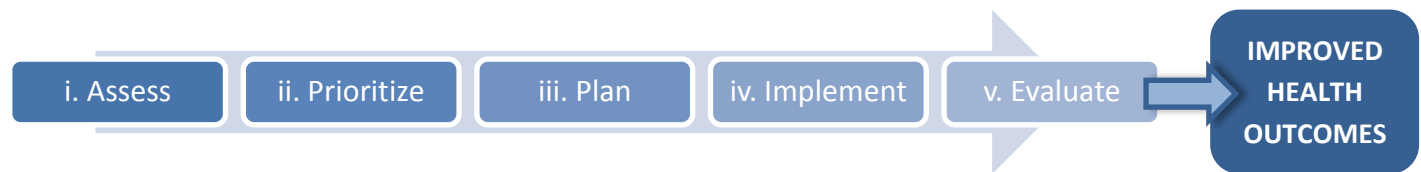
WHY COMMUNITY HEALTH ASSESSMENT IS IMPORTANT

Hospitals & Health Systems

The community health needs assessment is an important tool for hospitals in meeting their mission. The assessment allows hospitals to utilize available public health data as well as their own data to identify the needs of the community and direct their community benefit activities to address those needs. As a result of the passage of the Affordable Care Act and accompanying IRS requirements, completion of a community health needs assessment is required of **non-profit hospitals** every three years.

Public Health

Assessment is a foundational activity of public health and is a basis for setting priorities, planning, developing programs, seeking funding, and changing policy. Community health assessments in public health describe the health of the population, identify areas for improvement, identify contributing factors that impact health outcomes, and identify community assets and resources that can be mobilized to improve population health. These assessments provide the general public and policy leaders with information on the health of the population and the broad range of factors that impact its health. **Public health** assessment activities have recently been influenced by the Public Health Accreditation Board's[3] voluntary Standards and Measures document which serves as the official guide for public health department accreditation. Community health assessment requirements are outlined in Standard 1.1.

Health Plans

Local public health community health assessments, Minnesota public health goals and health plans' own data analyses are used to determine health plan priority areas. **Health Plans** are required by the State to collaborate with local public health departments on public health goals. In 2010, Minnesota allowed the health plans to submit one collaboration plan for its seven health plans. Priority areas become the focus of collaborative health improvement efforts. The collaboration plan has evolved from a report to a

---

[1] **Community Health Assessment** and **Community Health Needs Assessment** are used interchangeably throughout this document with both referring to the systematic collection of data and information to be used in the development of strategies to address a community's health.

[2] Center for Disease Control (CDC) **www.cdc.gov/policy/ohsc/docs/currentanddesired_frameworks.pdf**

[3] Public Health Accreditation Board (PHAB) **www.phaboard.org**

working document that can be used by stakeholders for collaboration and public health improvement.

WHAT ARE THE COMMUNITY HEALTH ASSESSMENT TASKS BY SECTOR

	HEALTH PLANS*	HOSPITALS & HEALTH SYSTEMS	PUBLIC HEALTH
FREQUENCY	Every 5 years	Every 3 years	At least every 5 years
REQUIREMENT	Minn. Stat. 62Q.075	Affordable Care Act	Minn. Stat. 145A
REPORTING	To MDH	To IRS, Form 990 Schedule H	To MDH
AVAILABILITY OF COLLABORATIVE PROCESS MODELS OR TOOLKITS		ACHI Toolkit, Catholic Hospital Association Assessing Community Health Needs	Mobilizing for Action through Planning and Partnerships (MAPP)
TASKS THAT ARE COMMON ACROSS SECTORS	Describe target population/audience		
	Develop an assessment plan		
	Partner with other community sectors		
	Review primary and secondary data		
	Collect quantitative and qualitative data		
	Analyze all data		
	Seek community input		
	Describe causes that contribute to the identified health issues		
	Describe existence and extent of health disparities		
	Describe community assets and resources available to address priority health issues		
	Inform partners and community organizations about the assessment		
	Communicate findings to the public		
	Monitor and update findings on an ongoing basis		

*Although individual health plans do the tasks listed under community health assessment for their organizations, it is not a requirement of the collaboration plan. Health plans work with local public health and hospitals on community health assessments through collaborative projects.

ONLINE RESOURCES

Minnesota Council of Health Plans Collaboration Plan   www.mnhealthplans.org/tools/documents/20091223CollaborationPlan.pdf

Minnesota Department of Health Local Public Health Assessment and Planning   www.health.state.mn.us/divs/opi/pm/lphap

Minnesota Hospital Association Community Health Needs Assessment   www.mnhospitals.org/data-reporting/mandatory-reporting/community-health-needs-assessment

This document was created based on materials from the Center for Community Health
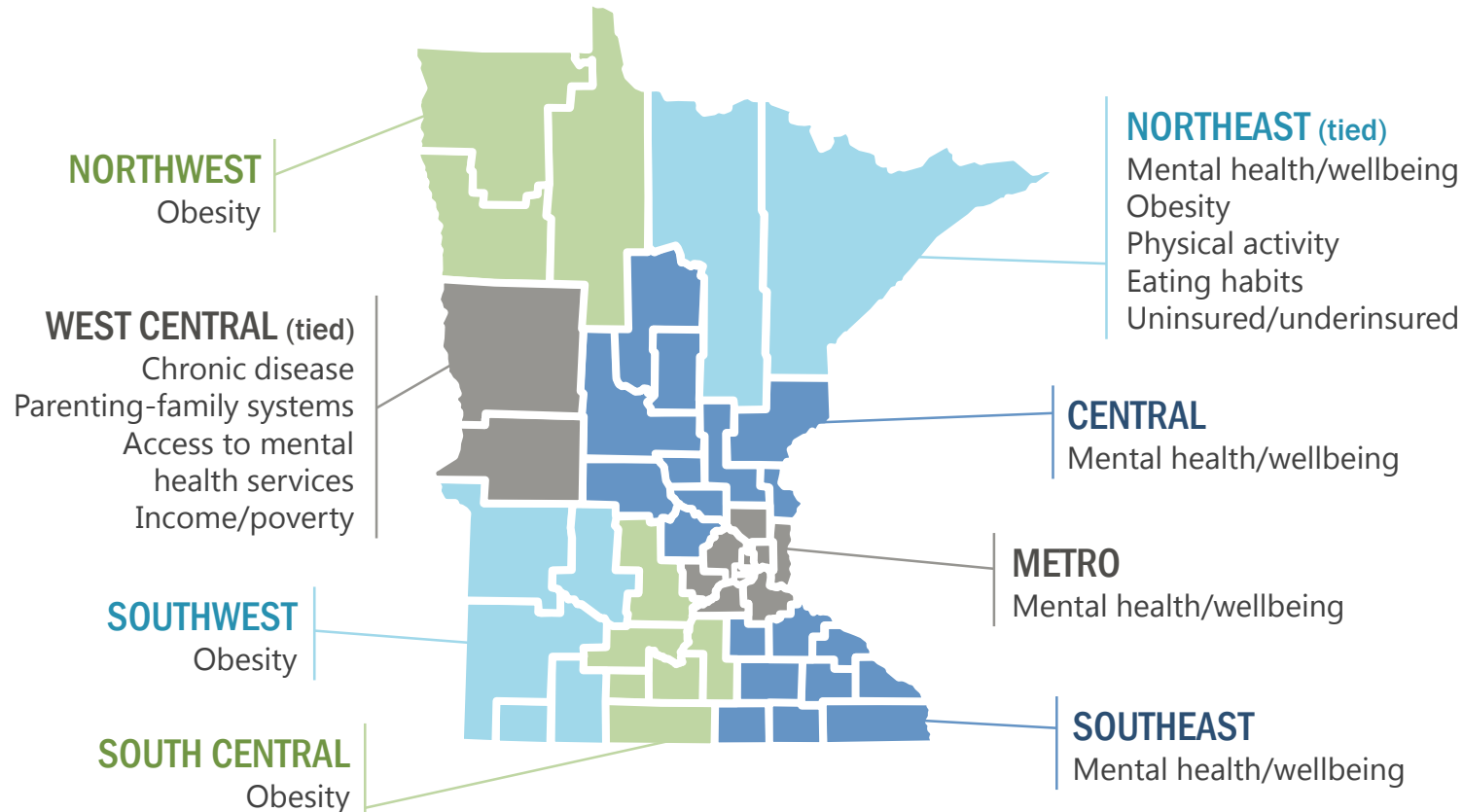
Minnesota's Most Important Community Health Issues

In Spring 2015, Minnesota's 48 community health boards (CHBs) identified the 10 most important community health issues in their CHBs, based on their community health assessment. A community health assessment provides the foundation for improving and promoting the health of the community; it identifies and describes: (1) the health status of the community, (2) the factors that contribute to health challenges, and (3) existing community assets and resources that the community can mobilize to improve the health status of its residents.
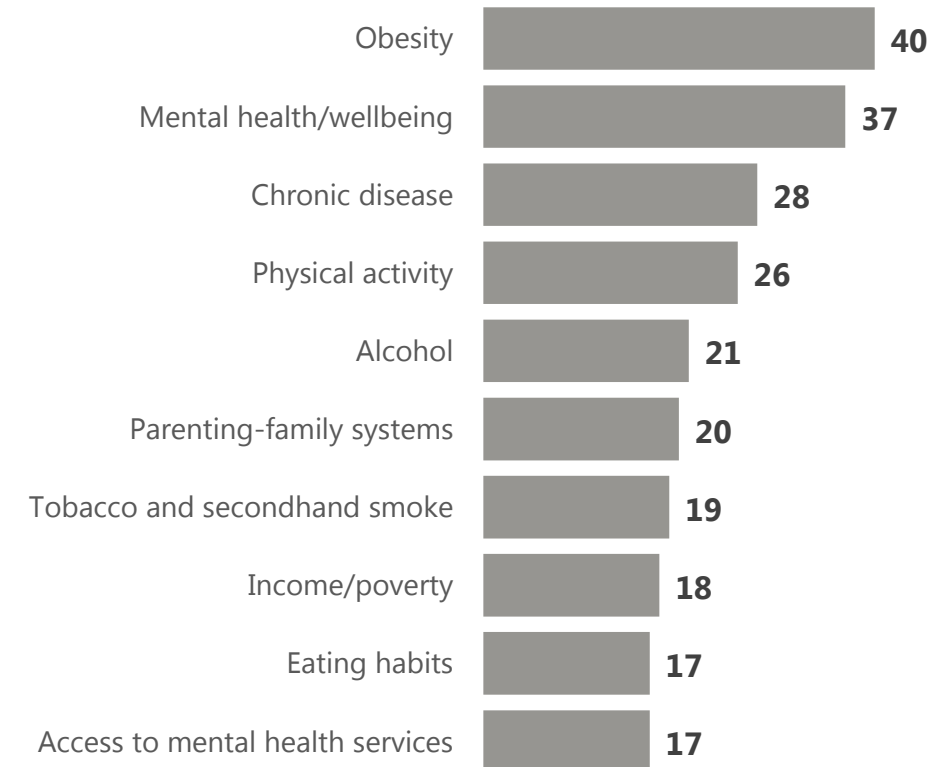
REGIONAL HEALTH ISSUES

Community health issues most frequently identified as most important in each region

NORTHWEST
Obesity

WEST CENTRAL (tied)
Chronic disease
Parenting-family systems
Access to mental health services
Income/poverty

SOUTHWEST
Obesity

SOUTH CENTRAL
Obesity

NORTHEAST (tied)
Mental health/wellbeing
Obesity
Physical activity
Eating habits
Uninsured/underinsured

CENTRAL
Mental health/wellbeing

METRO
Mental health/wellbeing

SOUTHEAST
Mental health/wellbeing

STATEWIDE HEALTH ISSUES

Community health issues most frequently identified as most important by Minnesota's 48 CHBs

Issue	Count
Obesity	40
Mental health/wellbeing	37
Chronic disease	28
Physical activity	26
Alcohol	21
Parenting-family systems	20
Tobacco and secondhand smoke	19
Income/poverty	18
Eating habits	17
Access to mental health services	17

05/2015

MINNESOTA
MDH
DEPARTMENT of HEALTH

Preliminary report on priority health needs in Minnesota hospitals' and health systems' Communities

Minnesota's hospitals and health systems have a long history of providing a range of vital services for the communities they serve. Most often, we associate Minnesota's hospitals and health systems with the nation-leading, high-quality health care services they provide to patients 24 hours a day, 7 days a week. Because almost all of our hospitals and health systems are nonprofits, either private charitable organizations or public entities, they also deliver a tremendous amount of community benefit activities that include free or discounted care for uninsured, under-insured or government-insured residents; community health services and initiatives; health education and wellness programs; and on and on.

As part of the Patient Protection and Affordable Care Act (ACA), the federal government required each charitable hospital to assess the health needs of its community, prioritize those needs, and describe how the hospital plans to address those needs in the years ahead. Almost all of Minnesota's charitable hospitals and many of its public hospitals have completed these newly required community health needs assessments (CHNAs), which can be found on each hospital's website or collectively at the Minnesota Hospital Association's website: http://www.mnhospitals.org/policy-advocacy/priority-issues/community-benefit-activities/community-health-needs-assessment.

The Minnesota Hospital Association (MHA) began an analysis of our hospitals' and health systems' CHNAs to identify common themes or trends, find uncommon needs that two or more hospitals might intend to tackle without otherwise knowing about the other's efforts, and raise awareness of both the unmet needs in our communities that demand highly effective and sustainable health care delivery systems as well as the ambitious undertakings that Minnesota's hospitals and health systems are embarking upon to address those needs. That work began with the cataloging of the highest priority community health needs that hospitals and health systems identified and intend to address: http://www.mnhospitals.org/Portals/0/Documents/misc/HospitalandHealthSystemCommunityHealthNeeds.pdf.

This is the first report among what we expect will be a series of summaries, highlights, and analysis that stem from the large amount of information gathered by 84 hospitals and health systems throughout the state. As more hospitals complete their assessments, we will incorporate their data and conclusions. At this early stage, the information in this report focuses on broad, general themes and trends that have emerged from MHA's review of the CHNAs of our members.

Theme 1: Health Care and Health Needs are Local

Although the data in Minnesota hospitals' and health systems' contain health needs, such as obesity and mental health, that cut across many communities throughout the state, perhaps the most prominent message contained within the data is the highly localized character of community health needs in Minnesota. As MHA attempted to catalog the findings contained in the CHNAs, it became clear that each local community had its own needs that defied a uniform, cookie-cutter description.

Although MHA grouped these needs into categories for the sake of our analysis, we emphasize the fact that there is tremendous diversity both across the dozens of categories we used as well as within each of those categories. For example, MHA used a category of mental health to note those communities that identified any number of mental health needs ranging from depression and suicide prevention, to social connectedness and mental health workforce shortages.

Another key observation is that each hospital and its community examined their health needs, engaged businesses and residents, and prioritized their findings in a manner that was unique. Consequently, each hospital and its community have a tailored assessment of the status of its population's health needs, its own priorities among those needs, and its own strategies for addressing those needs in the years ahead. These CHNAs, therefore, emphasize the importance of avoiding one-size-fits-all approaches to the kinds of community benefit activities each charitable and public hospital undertakes to fulfill its community service mission for the communities and residents it serves.

Theme 2: Access to Care Remains a Challenge

Minnesota prides itself on the relatively small proportion of residents who lack health insurance. Long before the ACA, Minnesota recognized that health coverage was an important piece in providing residents meaningful access to life-saving care, as well as financially prudent primary and preventive care.

However, a community with a high proportion of its residents covered by health insurance is by no means assured of having access to needed care. Throughout Minnesota, hospitals and health systems heard from residents and businesses that identified access to care as one of the highest priority needs in their communities. This broad category of need includes those communities who struggle to recruit and retain sufficient numbers of primary care providers, who need certain specialists to deliver the kind of services their changing population needs, and who understand that keeping the care currently available in their area is one of their highest priorities.

Of the CHNAs analyzed at the time of this report 33 of 84 hospitals reported that increasing or maintaining access to health care is one of the greatest health needs in their communities, and another 15 hospitals specified the need for preventive and primary care services for their communities.

Theme 3: Obesity has Communities' Attention

While the nation as a whole struggles with increasing rates of obesity, and the higher rates of a long list of health conditions that accompany the condition, Minnesota's hospitals and health systems have identified this area as a priority. Of the 84 CHNAs reviewed, 57 listed obesity as one of their communities' highest health care needs. Combine these numbers with other areas caused by or associated with obesity, such as 23 hospitals that described the need for wellness, nutrition, physical exercise and similar initiatives that seem aimed at obesity-reduction; 19 that identified diabetes; 12 that noted heart disease, high blood pressure and cholesterol; and 12 that described chronic disease prevention and management and it is apparent that obesity will receive significant attention from Minnesota's hospitals and health systems.

Theme 4: Strained Mental Health System Leaves Unmet Needs

As demonstrated by the 45 out of 84 hospitals that identified mental health as one of their communities' highest priorities, it is clear that the need for mental and behavioral health care is a challenge for communities of all sizes and in every corner of the state. In addition, 27 hospitals noted that alcohol, controlled substance or prescription medication abuse are high priority needs in their communities. Accordingly, Minnesota's hospitals and health systems recognize that they will play a critical role in addressing the workforce, outpatient, inpatient, transportation and other system capacity issues that leave existing resources stretched and strained.

The *County Health Rankings & Roadmaps* program and the *RWJF Culture of Health Prize* help communities identify and implement solutions that make it easier for people to be healthy in their homes, schools, workplaces, and neighborhoods. Ranking the health of nearly every county in the nation, the *County Health Rankings* illustrate what we know when it comes to what is making people sick or healthy. The *Roadmaps* show what we can do to create healthier places to live, learn, work, and play. The Robert Wood Johnson Foundation (RWJF) collaborates with the University of Wisconsin Population Health Institute (UWPHI) to bring this program to towns, cities, and counties across the nation.

WHAT ARE THE *COUNTY HEALTH RANKINGS*?

Published online at countyhealthrankings.org, the *Rankings* help counties understand what influences how healthy residents are and how long they will live. The *Rankings* are unique in their ability to measure the current overall health of each county in all 50 states. They also look at a variety of measures that affect the future health of communities, such as high school graduation rates, access to healthy foods, rates of smoking, obesity, and teen births.

Communities use the *Rankings* to garner support for local health improvement initiatives among government agencies, healthcare providers, community organizations, business leaders, policy makers, and the public.
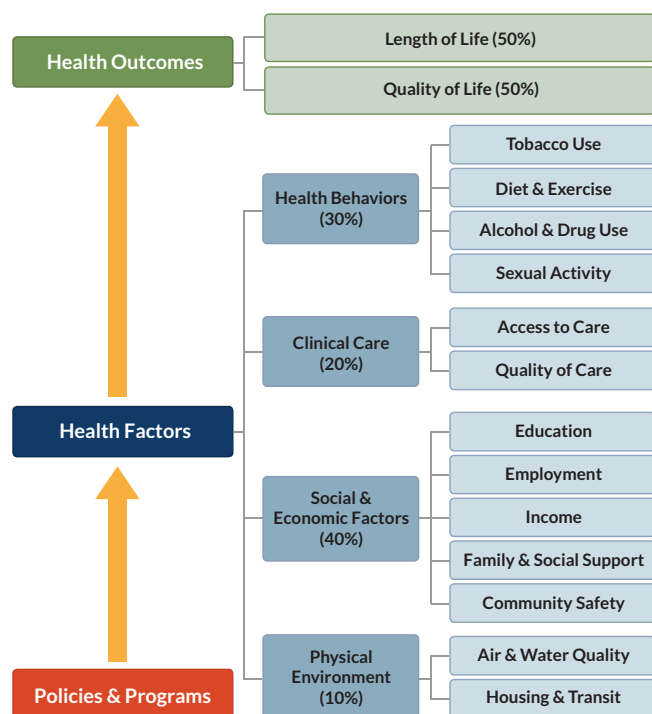
MOVING FROM DATA TO ACTION

The *Roadmaps to Health* help communities bring people together to look at the many factors that influence health, select strategies that work, and make changes that will have a lasting impact. The *Roadmaps to Health* Action Center is a one-stop shop of information to help any community member or leader who wants to improve their community's health. Within the Action Center you will find:

- Online step-by-step guidance and tools to move through the Action Cycle
- *What Works for Health* – a searchable database of evidence-informed policies and programs that can improve health
- Webinars featuring local community members who share their tips on how to build a healthier community
- Community coaches, located across the nation, who provide customized consultation to local leaders who have requested guidance in how to accelerate their efforts to improve health. You can contact a coach by activating the Get Help button at countyhealthrankings.org.

LEARNING FROM OTHERS

The *RWJF Culture of Health Prize* recognizes communities that are creating powerful partnerships and deep commitments to enable everyone in our diverse society to lead healthy lives now and for generations to come. The Prize is awarded annually by RWJF to honor communities that are working to build a Culture of Health by implementing solutions that give everyone the opportunity for a healthy life. In 2016 up to 10 winning communities will each receive a $25,000 cash prize and have their stories shared broadly with the goal of inspiring locally driven change across the nation.

Prize winners are selected based on how well they demonstrate their community's achievement on their journey to a Culture of Health in the following areas:

- Defining health in the broadest possible terms
- Committing to sustainable systems changes and long-term policy-oriented solutions
- Cultivating a shared and deeply held belief in the importance of equal opportunity for health
- Harnessing the collective power of leaders, partners, and community members
- Securing and making the most of resources
- Measuring and sharing progress and results

Visit rwjf.org/prize to learn about the work of past Prize winners and the application process.
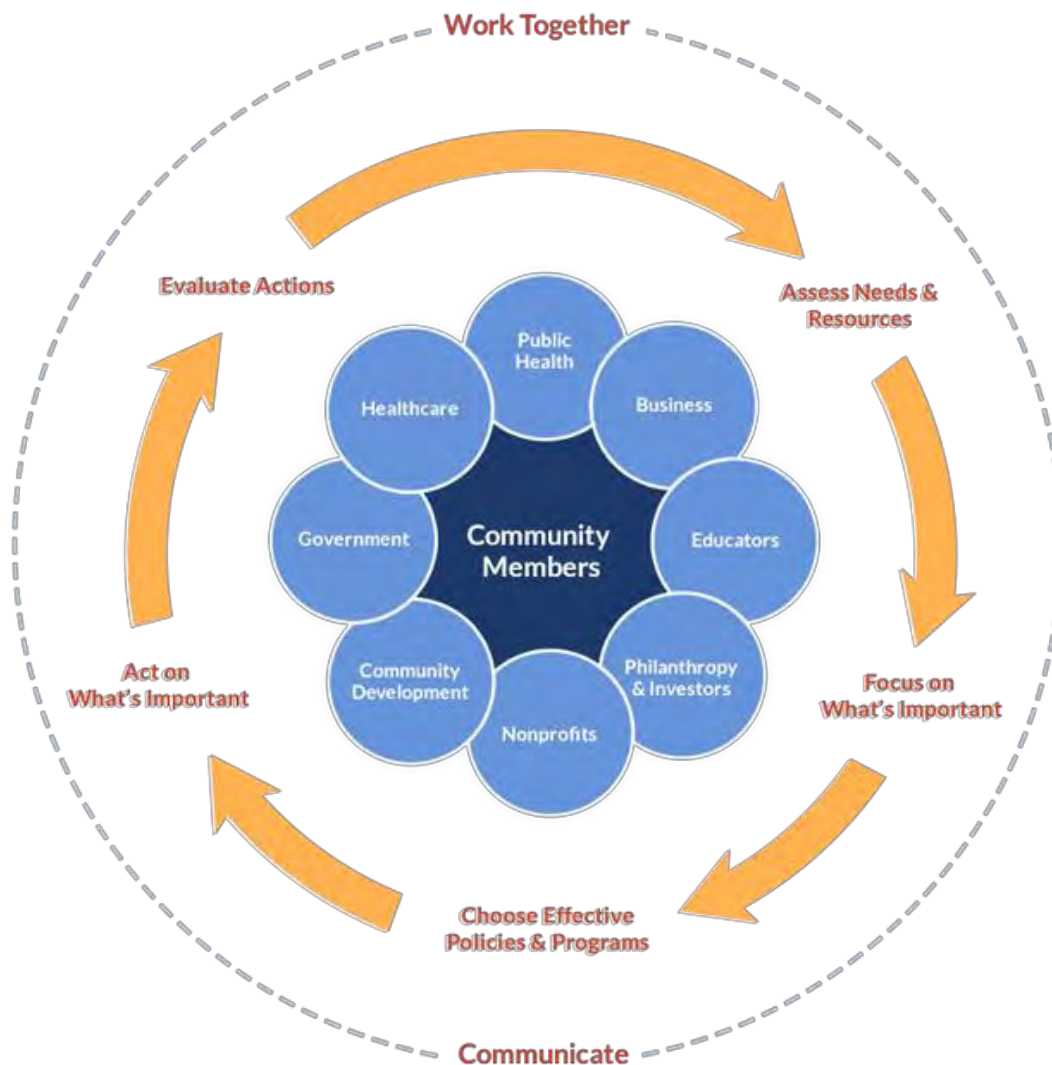

Past winners of the *RWJF Culture of Health Prize*

HOW CAN YOU GET INVOLVED?

You might want to contact your local affiliate of Local Initiatives Support Corporation (LISC), NeighborWorks, United Way Worldwide, or the National Association of Counties – their national parent organizations have partnered with us to raise awareness and stimulate action to improve health in their local members' communities. By connecting with other leaders interested in improving health, you can make a difference in your community. In communities large and small, people from all walks of life are taking ownership and action to improve health. Visit countyhealthrankings.org to get ideas and guidance on how you can take action in your community. Working with others, you can improve the health of your community.

A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

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

Support provided by

Robert Wood Johnson Foundation

Action Center

Each step on the Action Cycle is a critical piece of making communities healthier. There is a guide for each step that describes key activities within each step and provides suggested tools, resources, and additional reading. You can start at Assess or enter the cycle at any step. Work Together and Communicate sit outside because they are needed throughout the Cycle. At the core of the Action Cycle are people from all walks of life because we know we can make our communities healthier if we all get involved.

Roadmaps to Health Coaching is available to provide local leaders with direct support in using Action Center tools and guidance to advance health.

Adapted from County Health Rankings website to inform *Building Action Collaboratives for Health Improvement: A focused discussion of community needs*
05-15-2016

County Health Rankings & Roadmaps
Building a Culture of Health, County by County

Action Step	Description	Purpose	Key Activities
Work Together	Communities vary widely, and as a result, efforts to improve health will also vary. In the midst of all this variety is one constant: people working together. With a shared vision and commitment to improved health, working together can yield better results than working alone.	Build and sustain partnerships that reflect the diversity of your community so you can collaboratively implement strategies that result in meaningful change.	• Work together to address health inequities • Recruit diverse stakeholders from multiple sectors • Manage boundaries • Build Relationships • Build a common knowledge base • Develop the group's vision, values, and mission statement • Determine an organizational structure • Develop leadership capacity • Reinforce healthy partnership practices
Assess Needs and Resources	One of the first steps in local health improvement is to take stock of your community's needs, resources, strengths, and assets. You will want to understand what helps as well as what deters progress toward improving your community's health.	Understand current community strengths, resources, needs, and gaps to help you decide where to focus your efforts.	• Review your County Health Rankings snapshot • Prepare to assess • Generate questions • Identify community assets and resources • Collect secondary data • Collect primary data • Analyze the data • Share results with community • Address specific Assessment Requirements
Focus on What's Important	Once you've accounted for your community's needs and resources, it's time to decide which problem(s) to tackle. Without focus, all issues seem equally important. Taking time to set priorities will ensure that you direct your community's valuable and limited resources to the most important issues.	Focus your community's efforts and resources on the most important issues to achieve the greatest impact on health.	• Summarize needs and resources assessment • Determine your guiding question • Brainstorm possible priorities • Prepare to prioritize • Prioritize the issues • Analyze root causes • Finalize priorities • Communicate priorities

Action Step	Description	Purpose	Key Activities
Choose Effective Policies & Programs	Evidence matters. Taking time to choose policies and programs that have been shown to work in real life and that are a good fit for your community will maximize your chances of success.	Explore and select evidence-informed policies and programs to address priority issues.	• Define your goal • Explore policies and programs • Consider the impact • Consider the context • Select the best strategy
Act on What's Important	Once you've decided what you want to do, the next step is to make it happen. Since there are no "one size fits all" blueprints for success, communities build on strengths, leverage available resources, and respond to unique needs.	Take action—ensure that selected policies and programs are adopted and implemented in order to achieve intended results.	• Develop a strategy to take action • Develop a resource plan • Understand key decision makers • Build public and political will • Organize and mobilize the community • Develop/deliver your persuasive message • Sustain the work
Evaluate Actions	Evaluating your efforts is an important and ongoing part of improving your community's health. Evaluation helps you know if what you're doing is working the way you intended and achieving the results you desire.	Discover whether strategies are working as intended in order to focus efforts efficiently and effectively.	• Prepare to evaluate • Build consensus around an evaluation plan • Decide what goals are most important to evaluate • Determine your evaluation questions • Identify benchmarks for success • Collect credible data • Monitor progress toward benchmarks • Review evaluation results and adjust policy • Share your results
Communicate	Effective and continuous communication is essential for your efforts to be successful. It's important to consider how you will get your most important messages to the people who matter – both internally (how will you and your partners communicate with each other?) and externally (how will you communicate with others in your community?).	Ensure effective communication with your partners, develop strategic messages, and deliver those messages to the right people.	• Create common language • Keep partners informed and engaged • Develop a communications strategy • Persuade decision makers • Tell your story

Communities Drive the Process

Community ownership is a fundamental component of MAPP. Because the community's strengths, needs, and desires drive the process, MAPP provides the framework for creating a truly community-driven initiative. Community participation leads to collective thinking and, ultimately, results in effective, sustainable solutions to complex problems.

Communities Strengthen Local Public Health Systems

Broad community participation is essential because a wide range of organizations and individuals contribute to the public's health. Public, private, and voluntary organizations join community members and informal associations in the provision of local public health services. The MAPP process brings these diverse interests together to collaboratively determine the most effective way to conduct public health activities.

Materials to Help Communities Implement MAPP:

The MAPP Web site – full guidance and access to all supplemental resources are available to users through NACCHO's Web site at **www.naccho.org/mapp**. Access to the Web site is free. The following resources are available through the Web site:

- **MAPP Clearinghouse** – allows current and new MAPP users to browse, adopt, and tailor tools and resources that other MAPP users have used to complete the different phases of MAPP.

- **Technical Assistance Webcast Series** – features experienced MAPP users who share their insights on MAPP implementation issues and answer participants' technical assistance questions.

- **MAPP Peer Assistance Network (PAN)** – enables new users to connect with experienced peers for one-to-one guidance and provides links to stories from the field.

- **NACCHO's MAPP List Service** – disseminates information about new MAPP-related resources and events, including MAPP Trainings and funding opportunities.

- **MAPP Publications** – the Field Guide provides an easy-to-read, 24-page overview of the MAPP process, and the MAPP User's Handbook is a condensed, portable version of the Web-based process with practical tip sheets and worksheets.

For more information about MAPP, please contact:

NACCHO
National Association of County & City Health Officials
1100 17th Street, NW, Second Floor, Washington, DC 20036

P (202) 783-5550
F (202) 783-1583
mapp@naccho.org
www.naccho.org/mapp

NACCHO is the national organization representing local health departments. NACCHO supports efforts that protect and improve the health of all people and all communities by promoting national policy, developing resources and programs, seeking health equity, and supporting effective local public health practice and systems.

MAPP
MOBILIZING FOR ACTION THROUGH
PLANNING AND PARTNERSHIPS (MAPP)

A STRATEGIC APPROACH
to
COMMUNITY HEALTH IMPROVEMENT

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

CDC
CENTERS FOR DISEASE
CONTROL AND PREVENTION

Public Health
Prevent. Promote. Protect.

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-wide strategic planning process for improving community health. Facilitated by public health leadership, this process helps communities prioritize public health issues and identify resources for addressing them.

Carefully designed to provide useful and practical guidance, while at the same time offering enough flexibility to be adaptable to any community, each section of the MAPP process includes:

- Overview and guidance
- Tools and resources
- Stories from users
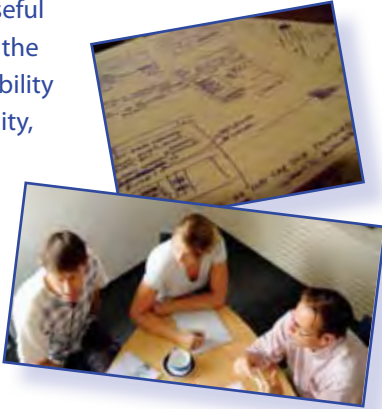
Vision for Implementing MAPP

"Communities achieving improved health and quality of life by mobilizing partnerships and taking strategic action."

The MAPP model and the illustrated "community roadmap" both depict the process communities will undertake when working with MAPP. To initiate the MAPP process, lead organizations in the community begin by organizing themselves, recruiting participants, and preparing to implement MAPP (**Organize for Success / Partnership Development**). The second phase of the MAPP process is **Visioning**. A shared vision and common values provide a framework for pursuing long-range community goals.

The **four MAPP Assessments** provide critical insights into challenges and opportunities throughout the community.

- **Community Themes and Strengths Assessment** – Identifies issues that interest the community, perceptions about quality of life, and community assets.

- **Local Public Health System Assessment** – Measures the capacity and performance of the local public health system—all organizations and entities that contribute to the public's health.

- **Community Health Status Assessment** – Assesses data about health status, quality of life, and risk factors in the community.

- **Forces of Change Assessment** – Identifies forces that are or will be affecting the community or the local public health system.

Using the results of the assessments, participants **Identify Strategic Issues** and then **Formulate Goals and Strategies** for addressing each issue. This information is crucial for the **Action Cycle**, during which participants plan for action, implement, and evaluate.

Conducting MAPP should create a sustained community initiative that ultimately leads to community health improvement.

The Local Public Health System Assessment is completed using the National Public Health Performance Standards Program (NPHPSP) local instrument. For more information on the NPHPSP, contact NACCHO (see back of brochure) or CDC: E-mail phpsp@cdc.gov, call (800) 747-7649, or visit www.cdc.gov/od/ocphp/nphpsp/index.htm.