Developing Goals, Objectives, and Performance Indicators for Community Health Improvement Plans (CHIPs)

May 9, 2012

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NACCHO
National Association of County & City Health Officials

Webinar Logistics

- The lines are muted. If you wish to mute/unmute your line to ask/answer a question, please do the following:
- To **unmute** your own line, **press *7**
- To **mute** your own line, **press *6.**

- Throughout the presentation and during the Q&A session, if you have a question, please use ReadyTalk's 'raise your hand' feature or use the chat box to indicate you have a question. The facilitator will call your name and ask for your question.

PROJECT REQUIREMENTS & PHAB STANDARDS AND MEASURES: DEVELOPING A CHIP

Project Requirements: Developing a CHIP

Engage Community Members and LPHS Partners

"Community members must be engaged in a meaningful and substantive way throughout the CHA and CHIP processes, including indicator selection, data collection, data analysis, data presentation and distribution, issue prioritization, **CHIP creation**, implementation of CHIP, and monitoring of results."

"Partners should be engaged in a strategic way **throughout the CHA and CHIP processes**, including gaining access to data, mobilizing community members, data collection, data review, issue prioritization, and CHIP implementation."

Project Requirements: Developing a CHIP

Address the Social Determinants of Health

- "Consider multiple determinants of health, especially social determinants like social and economic conditions that are often the root causes of poor health and health inequities among sub-populations in their jurisdictions."

- The project seeks to ensure that the CHAs conducted and the CHIPs developed have a particular focus on the following: Identifying populations within their jurisdictions with an inequitable share of poor health outcomes…**Including at least one of these issues as a priority for community health improvement efforts** in addition to other health priorities in the CHIP.

Project Requirements: Developing a CHIP

Required characteristics of the CHIP:

Background information that does the following:

- Describes the jurisdiction for which the CHIP pertains and a brief description of how this was determined.
- Briefly describes the way in which community members and LPHS partners were engaged in development of the CHIP, particularly their involvement in both the issue prioritization and strategy development.
- Includes a general description of LPHS partners and community members who have agreed to support CHIP action. Reference partners' participation in the short term and long term as applicable.

Priority issues section that does the following:

- Describes the process by which the priorities were identified.
- Outlines the top priorities for action. The priorities need to include at least one priority aimed at addressing a social determinant of health that arose as a key determinant of a health inequity in the jurisdiction.
- Includes a brief justification for why each issue is a priority.

Project Requirements: Developing a CHIP

Required characteristics of the CHIP cont'd:

A CHIP implementation plan that does the following:

- Provides clear, specific, realistic, and action-oriented goals.
- Contains the following:
  - **Goals, objectives, strategies, and related performance measures for determined priorities in the short-term (one to two years) and intermediate term (two to four years),**
  - **Realistic timelines for achieving goals and objectives.**
  - Designation of lead roles in CHIP implementation for LPHS partners, including LHD role.
  - Formal presentation of the role of relevant LPHS partners in implementing the plan and a demonstration of the organization's commitment to these roles via letters of support or accountability.
  - Emphasis on evidence-based strategies.
  - A general plan for sustaining action.

PHAB Requirements: Developing a CHIP

Be sure to review the standards listed below to identify the measures and required documentation that PHAB seeks related to developing a CHIP.

Standard 5.2: Conduct a comprehensive planning process resulting in a tribal/state/community health improvement plan

PHAB Requirements: Developing a CHIP

For example…

Measure5.2.1 L: Conduct a process to develop community health improvement plan
Required documentation: Completed community health improvement planning process that included 1a. Broad participation of community partners; 1b. Information from community health assessments; 1c. Issues and themes identified by stakeholders in the community; 1d. Identification of community assets and resources; and 1e. A process to set community health priorities.

Measure 5.2.2L: Produce a community health improvement plan as a result of the community health improvement process
Required documentation : CHIP dated within the last five years that includes 1a: Community health priorities, measurable objectives, improvement strategies and performance measures with measurable and time-framed targets; 1b. Policy changes needed to accomplish health objectives; c. Individuals and organizations that have accepted responsibility for implementing strategies; 1d. Measurable health outcomes or indicators to monitor progress; and 1e. Alignment between the CHIP and the state and national priorities.

PHAB Requirements: Developing a CHIP

For example…

Measure 5.2.3A: Implement elements and strategies of the health improvement plan, in partnership with others* *Required documentation:* 1. Reports of actions taken related to implementing strategies to improve health [Guidance:…provide reports showing implementation of the plan. Documentation must specify the strategies being used, the partners involved, and the status or results of the actions taken…]; 2. Examples of how the plan was implemented [Guidance: ..provide two examples of how the plan was implemented by the health department and/or its partners].

Measure 5.2.4A: Monitor progress on implementation of strategies in the CHIP in collaboration with broad participation from stakeholders and partners* *Required documentation:* 1. Evaluation reports on progress made in implementing strategies in the CHIP including: 1a. Monitoring of performance measures and 1b. Progress related to health improvement indicators [Guidance: Description of progress made on health indicators as defined in the plan...]; and 2. Revised health improvement plan based on evaluation results [Guidance: …must show that the health improvement plan has been revised based on the evaluation listed in 1 above…]

*** Not required as part of the CHA/CHIP Project**

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Learning Objectives

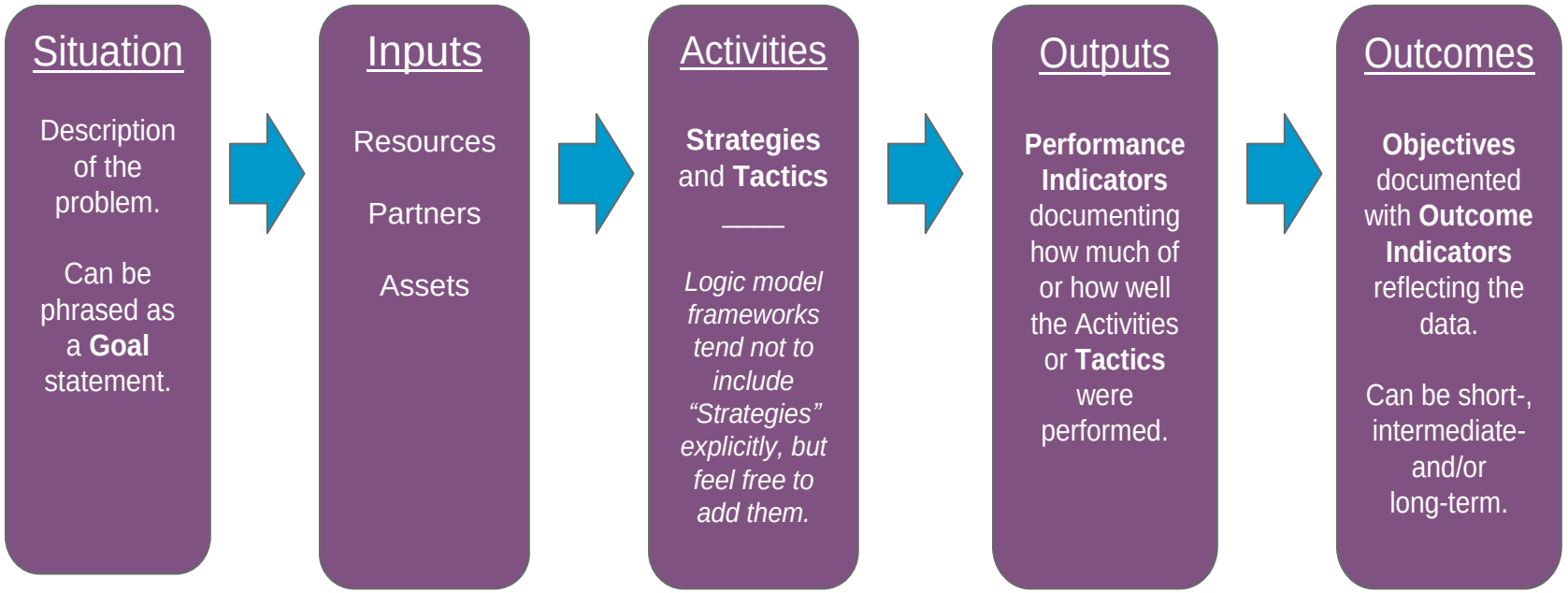
At the completion of the session participants will be able to:

1. State the difference between a goal and objective.
2. Write a realistic, measurable and time-framed objective.
3. Discuss how national guidance, such as Healthy People 2020 can be used to guide goal and objective development.
4. Create performance indicators for at least two activities.
5. Identify processes for monitoring achievement of goals and objectives.
6. Re-state the project and PHAB documentation requirements for goals, objectives and performance monitoring in the CHIP.

What Is A Logic Model?

- A **succinct series of statements** linking goals, objectives and resources to strategies, tactics and their performance, and outcomes
- It shows the **connections** between what you do and what you are trying to accomplish
- A tool to help you **identify** and clarify what you're trying to achieve, what you plan to do to get to there, and what you'll need to do this
- An easy way to quickly **show** what the project/program entails, looks like, and seeks to change
- It allows **stakeholders** to improve and refine the project/program
- It **reveals assumptions** about the conditions needed for the project/program to be effective and what the program is intended to do
- It is a "**road map**"

Logic Models to Illustrate "Theories of Change"



Two Useful Guides on Logic Models

United Way's Measuring Program Outcomes: A Practical Approach:
http://www.unitedwaystore.com/product/measuring_program_outcomes_a_practical_approach/program_film

Community Anti-Drug Coalitions of America, Assessment Primer: Analyzing the Community, Identifying Problems and Setting Goals:
http://www.cadca.org/resources/detail/assessment-primer

Component of a Plan: Example Statements

Goal: Reduce the use of marijuana and alcohol use by youth.

Objectives: a) Decrease the percentage of youth using marijuana from 20% to 15% by 2014.
b) Decrease the percentage of youth drinking alcohol from 50% to 30% by 2014.

Outcome Indicators: a) Percentage of middle and high school students indicating that they use marijuana.
b) Percentage of middle and high school students indicating that they drink alcohol.

Strategies: a) Provide information to youth about the dangers and consequences of using marijuana and alcohol.
b) Build the skills of parents and other adults to talk with their children about the dangers and consequences of using marijuana and alcohol.
c) Reduce the access of marijuana and alcohol in the community.

Tactics: a) Provide marijuana and alcohol awareness programs to youth in middle and high schools.
b) Provide workshops for parents and create parent chat groups
c) Work with law enforcement to do local vendor compliance checks on alcohol sales to minors.
d) Set up a tip line on marijuana sales.

Performance Indicators: a) Pre- and post test results of youth participating in awareness programs.
b) Number of parents attending workshops.
c) Number of parents participating in chat groups.
d) Number of vendors who pass alcohol compliance checks.
e) Number of calls to the tip line.

Example of a Logic Model Using the Previous Statements

Situation	Inputs	Activities	Outputs	Outcomes
Goal: Reduce the use of marijuana and alcohol use by youth	Local School System PTAs Police Department Chamber of Commerce Funding	Provide information to youth about the dangers & consequences of using marijuana & alcohol -Provide marijuana and alcohol awareness programs to youth in middle & high schools	Pre-and post test results of youth participating in awareness programs	Decrease the % of youth using marijuana from 20% to 15% by 2014 -% of middle & high school students indicating they use marijuana - % of middle & high school students indicating they drink alcohol
		Build the skills of parents & other adults to talk with their children about the dangers & consequences of using marijuana and alcohol -Provide workshops for parents and create parent chat groups	Number of parents attending workshops Number of parents participating in chat groups	
		Reduce the access of marijuana & alcohol in the community - Work with law enforcement to do local vendor compliance checks of alcohol sales to minors - Set up a tip line on marijuana sales	Number of vendors who pass alcohol compliance checks Number of calls to the tip line	

Examples of Population Outcomes

Outcomes: Measurable changes in behaviors, attitudes or conditions.

Goal: Decrease the number of low birth weight births so more infants live after birth.

Objective: By 2013-2015, the three year rolling average for low birth weight births will decrease from 8.5% in 2009-2011 to 7.8%.
Outcome Indicator: Percentage of low birth weight births annually and the average percentage of low birth weight births over a three time period.

Goal: Reduce the rate of teenage pregnancies.
Objective: By 2015, reduce the rate of teen pregnancies from 30 per 1,000 teenagers (aged 12-19) to 27 per 1,000 teenagers.
Outcome Indicator: The number of teen pregnancies per 1,000 teenagers annually.

Goal: Decrease the number of families living in shelters.
Objective: By 2014, the number of homeless families living in shelters will decrease from 146 in 2012 to 130.
Outcome Indicator: The number of homeless families living in shelters annually.

Examples of Performance Indicators

Performance Indicator: A measure of the extent to which a tactic has been accomplished.

Tactic: Provide counseling to at-risk pregnant females about the impact of smoking on the birth weight of their baby.

Performance Indicator: a) The number of counseling sessions provided.

b) The number of at-risk pregnant females who participated in counseling sessions and who stop smoking during pregnancy.

Tactic: Implement a text-line for youth to ask questions and receive answers about sex.

Performance Indicator: a) Number of questions submitted on a monthly basis.

b) Amount of time to respond to questions.

Tactic: Create and deliver a financial literacy education program for homeless families.

Performance Indicator: a) Percentage of homeless families who participated in the financial literacy education program.

b) Pre- and post-test of families who participated in the financial literacy education program.

An Example of a Monitoring Process

- Establish a team responsible for monitoring progress of (1) objectives and outcome indicators and (b) tactics and performance indicators.
- Report out progress information (objectives and outcome indicators and tactics and performance indicators) to steering committee or governing committee and all partners. This can be done monthly, every 3 months, every 6 months or annually depending on when outcome and performance data are available.
- Hold assessment sessions to discuss “How are we doing?”
    - What is going well? Why?
    - What is not going well? Why?
    - What changes or improvements are needed regarding the tactics? Develop a plan and implement changes or improvements

****The key is to develop a monitoring process to provide continuous feedback on how well things are going and to make changes/improvements when necessary.**

Collaborating for Health Improvement: A MAPP-based Approach St. Clair County, Illinois

Wednesday, May 9, 2012

Mark Peters, MS
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St. Clair County Health Department

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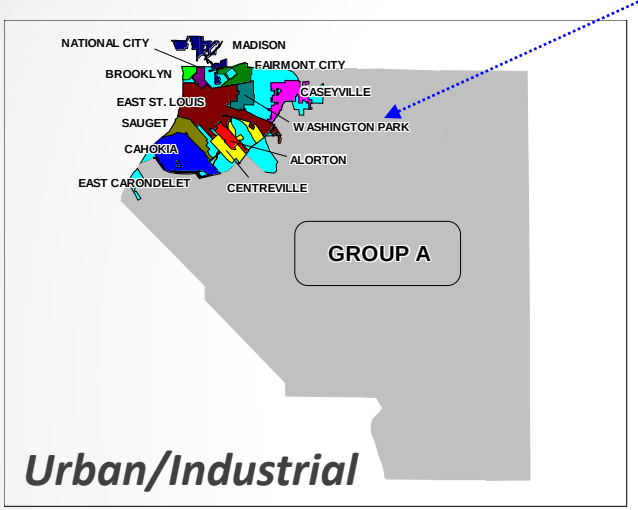
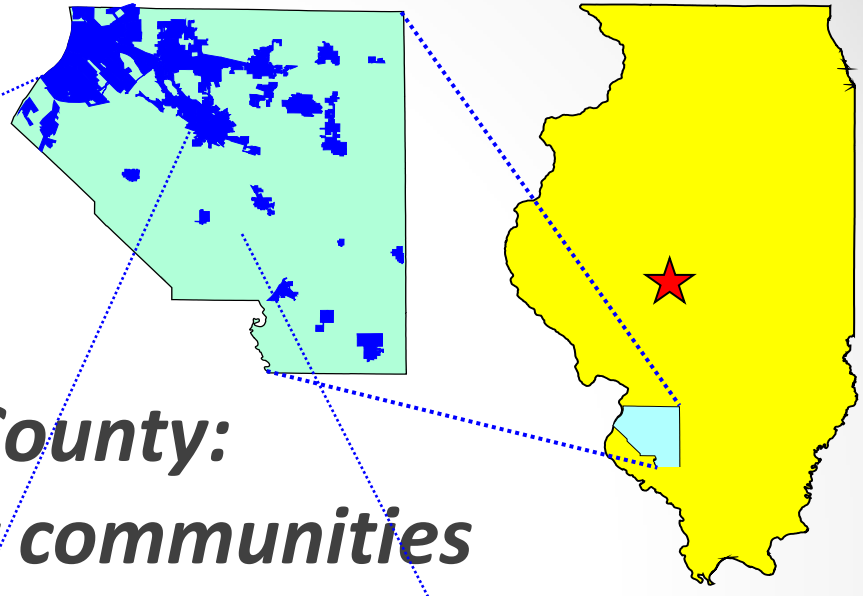
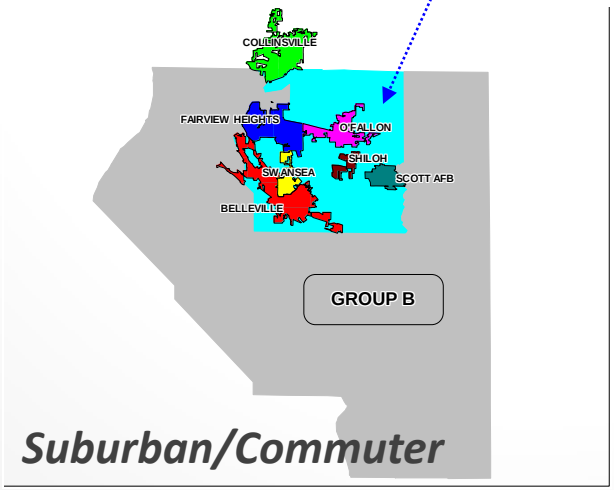
National Association of County & City Health Officials

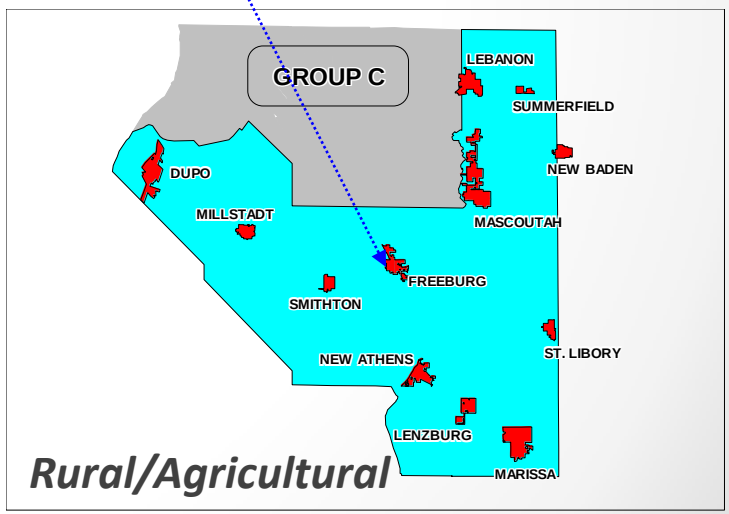
St. Clair County, Illinois





One County:
Many communities





SCC Health Care Commission

- **Coalition** of major health providers and community based organizations
- **Committed** to common cause of health improvement
- **Convened** by Public Health Board with support of County Board

ST. CLAIR COUNTY
HEALTH CARE COMMISSION
PARTNERS FOR HEALTH

Who Serves on the Commission?

County Office on Aging

Mental Health Board

Community Hospitals

East Side Health District

Community Health Center

St. Clair County Health Dept

Medical Society

Scott Air Force Base

SIUE School of Nursing

Programs/Services Older Persons

Regional Office of Education

Community Based Organizations

ST. CLAIR COUNTY
HEALTH CARE COMMISSION
PARTNERS FOR HEALTH

Our Goal

Partners for health improvement through prevention.

Our Principles

- Collaboration not competition
- Coordination not control
- Communication with confidentiality
- Common goals with consideration of individual mission
- Capitalize on community strengths
- Collective Commitment to community health improvement

Mobilizing for Action through Planning and Partnerships (MAPP)

A strategic approach to community health improvement. This tool helps communities improve health and quality of life through community-wide and community-driven strategic planning.

A ***six-phase process*** of community health assessment and planning.

MAPP Model


Community Themes & Strengths Assessment
Organize for Success
Partnership Development
Visioning
Four MAPP Assessments
Identify Strategic Issues
Formulate Goals and Strategies
Evaluate
Plan
Action
Implement
Forces of Change Assessment
Local Public Health System Assessment
Community Health Status Assessment

2006-11 MAPP Strategic Issues

How can the St. Clair County health care community:

- create a broader community connectedness
- strengthen the public health workforce
- address the needs of those who require behavioral health services
- improve health outcomes for cardiovascular diseases, maternal and child health and respiratory diseases
- improve health services to the aging community
- improve access to care
- reduce incidence of sexually transmitted disease*

* added in 2008

ST. CLAIR COUNTY
HEALTH CARE COMMISSION
PARTNERS FOR HEALTH

2011-16 MAPP Strategic Issues

- **Risk Factor Prevention for Chronic Disease**
  - **Obesity (Active Living/Healthy Eating)**
  - **Tobacco Use**
- **Maternal and Child Health**
  - **Infant Mortality**
  - **Teen Pregnancy**
- **Behavioral Health**
  - **Suicide Prevention**
  - **Substance Abuse**
- **Violence Prevention & Safety**
  - **Homicide**
  - **Domestic Violence**
  - **Neighborhood Safety**

ST. CLAIR COUNTY
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2011-16 MAPP Strategic Issues

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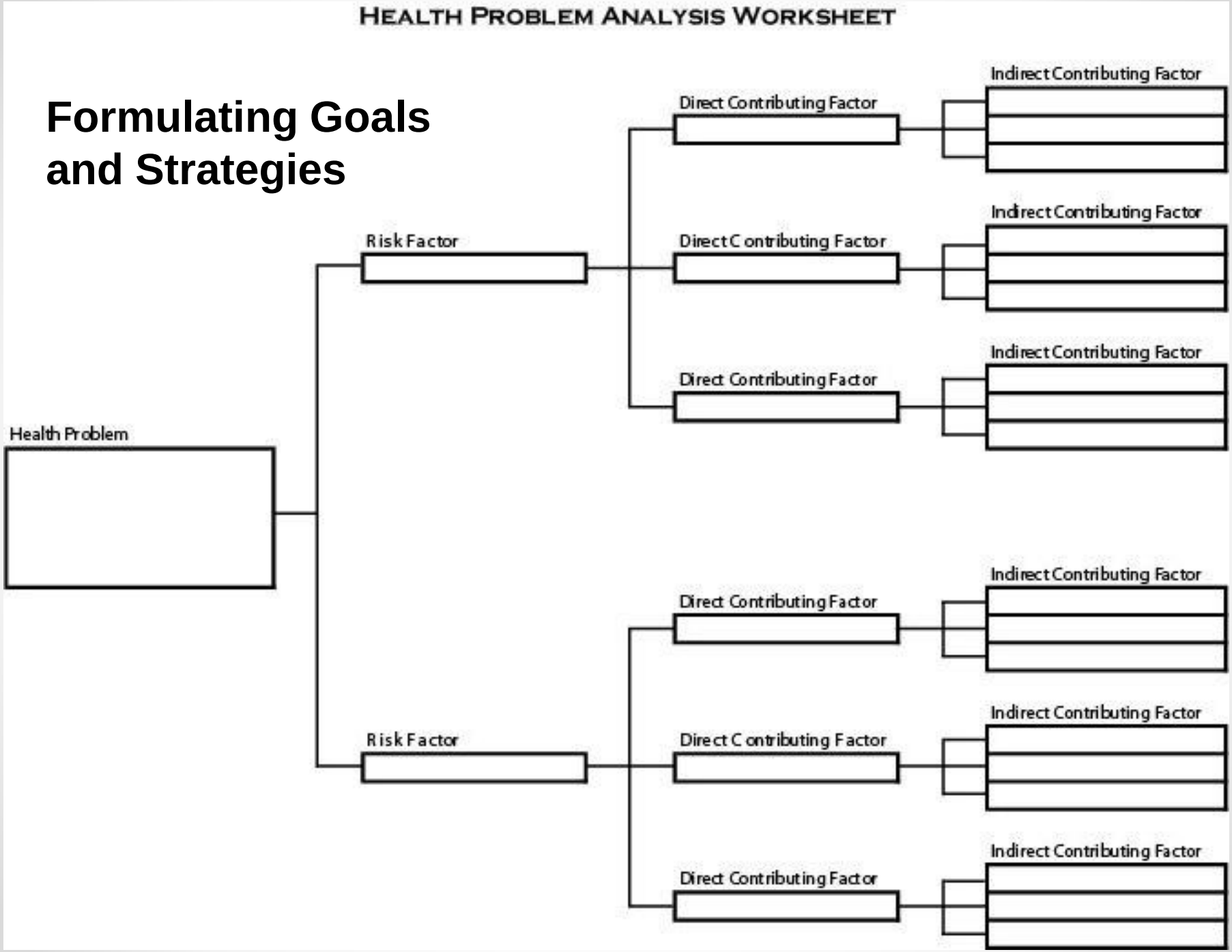
  - Teen Pregnancy
- **Behavioral Health**
  - Suicide Prevention
  - Substance Abuse
- **Violence Prevention & Safety**
  - Homicide
  - Domestic Violence
  - Neighborhood Safety

Action Teams forming within each area.

ST. CLAIR COUNTY
HEALTH CARE COMMISSION
PARTNERS FOR HEALTH

Formulating Goals and Strategies



Establish SMART Outcome & Impact Objectives:

- **Simple**
- **Measureable**
- **Achievable**
- **Relevant**
- **Time-based**

Health Problem: Chronic Disease	**Outcome Objective:**
Morbidity and Mortality due to select chronic diseases: • Diabetes • Heart Disease • Lung Cancer and COPDs.	By the year 2016, reduce the premature mortality rates per 100,000 population for Lung Cancer, COPD, Heart Disease and Diabetes to 34.1, 19.5, 77.1 and 20.2, respectively (20 percent of their current rate).
Risk Factor(s): • Tobacco Use • Inactive Lifestyle • Environmental Factors • Ambient Air Conditions • Poor Eating Habits	**Impact Objective(s):** • By the year 2013, reduce the percent of adults (age 18 and older) who consumes less than 5 servings of fruits and vegetables per day from 79.8 percent (2007 BRFSS) to 60 percent. • By the year 2013, reduce the percentage of adults who report doing no leisure time exercise or physical activity in the past 30 days from 24.3 percent (2009 SMART BRFSS) to 20 percent. • By the year 2013, improve attendance and participant compliance of local smoking cessation programs among community support and treatment organizations by 10 percent annually.
Contributing Factors (Direct/Indirect): • Influence of peers, family and culture • Lack of smoke-free policy and programs for smoking awareness and cessation • Access to Healthy Affordable Foods • Level of addiction • Stress/financial burden for employer/healthcare system • Educational Attainment	**Intervention Strategies:** • Increase promotion of QUITLINE and local Tobacco Cessation programs • Increase promotion of alternatives to leaf burning • Increase the participation of communities and schools in the County's Get Up & Go Campaign • Utilization of media and cessation products • Enhance screening, counseling and referral among healthcare providers • Expand advocacy participation among state level • Strengthen workplace enforcement, screening, referral and hiring policies
Community Stakeholders & Resources: • McKendree University • Get Up & Go! Health and Wellness Campaign • SIUE School of Nursing • Memorial Hospital • St. Elizabeth's Hospital • St. Clair county Health Care Commission	**Barriers to be Addressed:** • Participant follow-up and monitoring of progress • Funding shortages • Effectively marketing to population 18-40 years of age • Lack of inter-agency referral and policy enforcement

Related Healthy People 2020 Objectives:

- **D–3:** Reduce the diabetes death rate. Target: 65.8 deaths per 100,000 population.
- **D–16.1** Increase the proportion of persons at high risk for diabetes with pre-diabetes who report increasing their levels of physical activity. Target: 49.1 percent.
- **HDS–2:** Reduce coronary heart disease deaths. Target: 100.8 deaths per 100,000 population.
- **C–2:** Reduce the lung cancer death rate. Target: 45.5 deaths per 100,000 population.

The IDEAS for Action Exist,

- Create Sustainable community gardens in all 22 townships of St. Clair County
- Monitor trends from BRFSS nutrition & physical activity responses.
- Create GIS maps for youth obesity, physical activity, & nutrition
- Collect & communicate hospital discharge data on obesity-related diagnosis, BMI, zip code
- By 2012 all hospitals in the county will work with St. Clair County Health Department to implement a surveillance system to track BMI and obesity-related diagnoses (Adult Data).
- Encourage parents exercising with kids - using PTA/PTC School wellness councils, etc
- Use Get Up & Go! to organize bulk purchase of items to improve fitness & corporate fitness program.
- Promoting events via Media (consolidate and spread the word on events)
- Increase Community Competitions for Family Friendly Fitness Events
- Target more programs for "At-Risk" populations.
- Help communities collaborate and share resources.

Including a Long Lists of Partners, but…

St. Clair County Health Care Commission and Affiliate Members

- Allsup, Inc.
- American Heart Association
- American Lung Association
- Area Agency on Aging
- Asthma Coalition for the Greater St. Louis Metro East Area
- East Side Health District
- Get Up & Go! Health and Wellness Campaign
- March of Dimes
- McKendree University
- Memorial Hospital
- Pioneering Healthier Communities Initiative
- Programs & Services for Older Persons
- Regional Office of Education
- Scott Air Force Base Health and Wellness Center
- St. Clair County Health Department
- St. Clair County Medical Society
- St. Clair County Mental Health Board
- St. Clair County Office on Aging
- St. Clair County Youth Coalition
- St. Elizabeth's Hospital
- St. Mary's Hospital
- Southwestern Illinois Coalition Against Tobacco
- Southern IL Health Care Foundation
- Southern Illinois University, School of Nursing
- Southwest Illinois College
- Southwest Illinois HIV/AIDS Coalition
- Touchette Regional Hospital
- Willard C. Scrivner, MD Public Health Foundation
- YMCA of Southwest Illinois

But WHO is Doing WHAT?

MAPP Model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* added in 2008

ST. CLAIR COUNTY
HEALTH CARE COMMISSION
PARTNERS FOR HEALTH

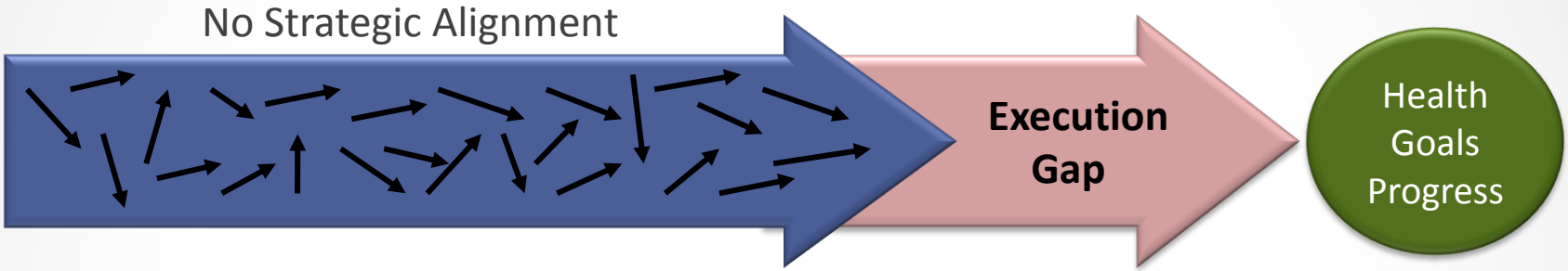
Create Community Connectedness

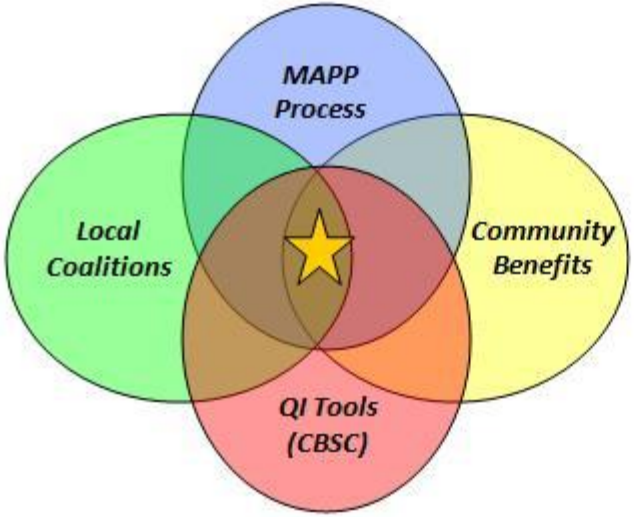
Launched "Get Up & Go" campaign

Mark Fenton, Host of the PBS series, *America's Walking*, keynote speaker at Health Policy Summit.

Annual health conferences

We Needed to Improve Alignment & Execution

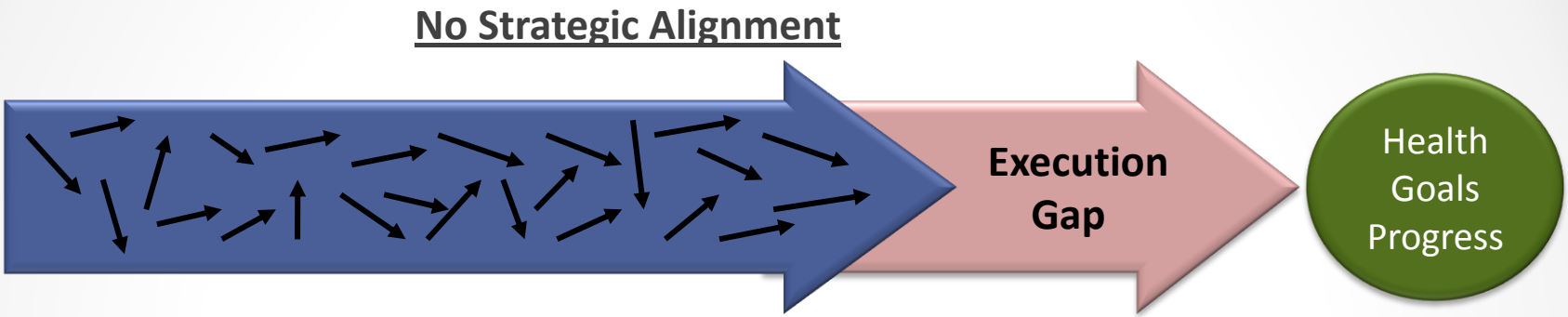


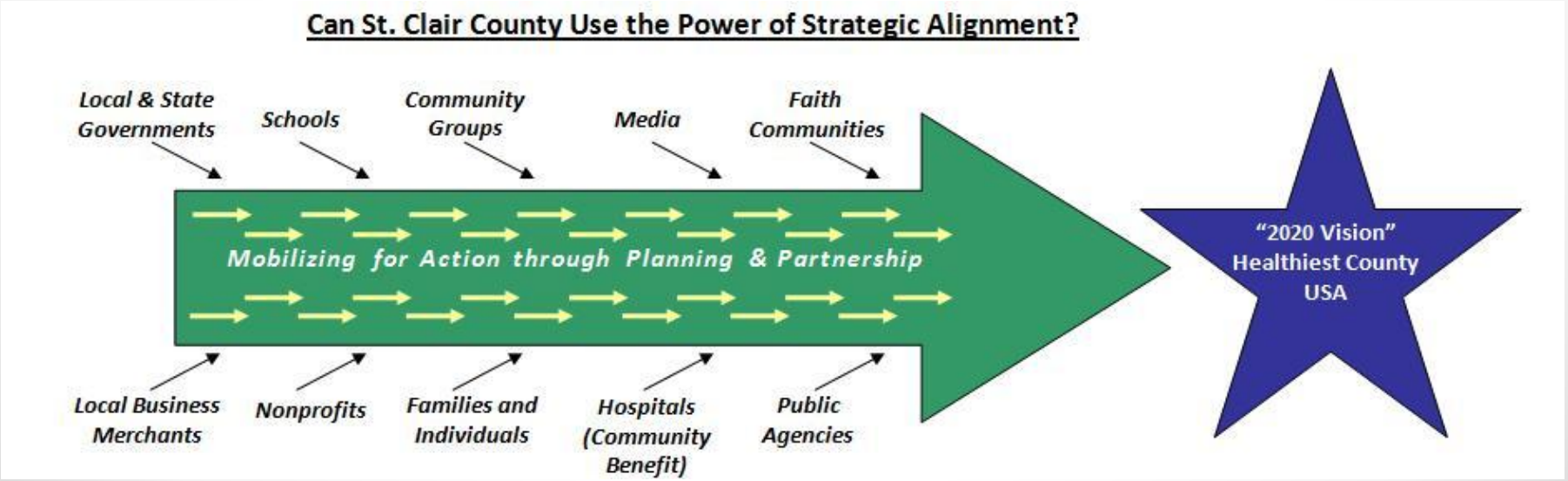


In 2009 the Health Care Commission was introduced to

Community Balanced Scorecards

The Need to Collaborate around a Strategy





Phase Six: the Action Cycle

Continuous Quality Improvement

Extracted Content from Existing Documents

From Nov 2009 Health Policy Summit

Mascoutah, Scott AFB

Project - Create more parks as community destinations, and increase bike/walk access from neighborhoods, including increased pathways, bike lanes, and specifically enhance safety by increasing placement of pedestrian signals at intersections.
Policies - Schools policies to support physical activity: Specifically schools must allow shared use facilities (for evenings, weekend physical activity programs, etc.) and begin instituting remote drop-off areas for walking to school (e.g. nearby church or park)
Big Goal - Schools as centers of healthy education, both nutrition and physical activity. Specifically increased community gardens, seniors involved in maintaining gardens, healthy cooking classes as well as required daily physical activity in all schools, mandatory.

McKendree University, Lebanon

Project - Get more involved in the school campuses around the county; get college students formally engaged in this work through classes & public service projects.
Big Goal - Promote more physical activity and healthy eating in the school setting, and increase understanding among students of the importance of these two.

O'Fallon

Projects - Community gardens are started, but have to grow and increase access, to community in general.
Also - Parks with facilities (such as skate parks) are pretty good, but need to make better connecti for non-motorized access
Big Goal - Dust off 2005 bicycle plan, and make sure there are safe designated bicycle facilities throughout the area. Have to built implementation of bike plan into every routine decision, subdivision and city planning effort.

Smithton & Freeburg

Projects - Develop a bike trail to connect Smithton, Freeburg & Millstadt.
Policy - Adopt county wide development policies to include requirements for green space, walking, biking trails, and mixed use development (e.g. neighborhood parks, etc) in all development throughout the county.
Big Goal - Over time connect this trail to the larger metrolink trail system.

Mixed group

From the CPPW Grant Application

Appendix F
Community Action Plan

Project Goals with S.M.A.R.T. Objectives and Strategies (bulleted)

Goal 1: Develop the capacity of St. Clair County Schools to provide a healthy environment for children & adolescents.

Obj 1h. By 2011 25% of public elementary schools in St. Clair County will adopt a standardized curriculum for media literacy specific to healthy eating and active lifestyles.

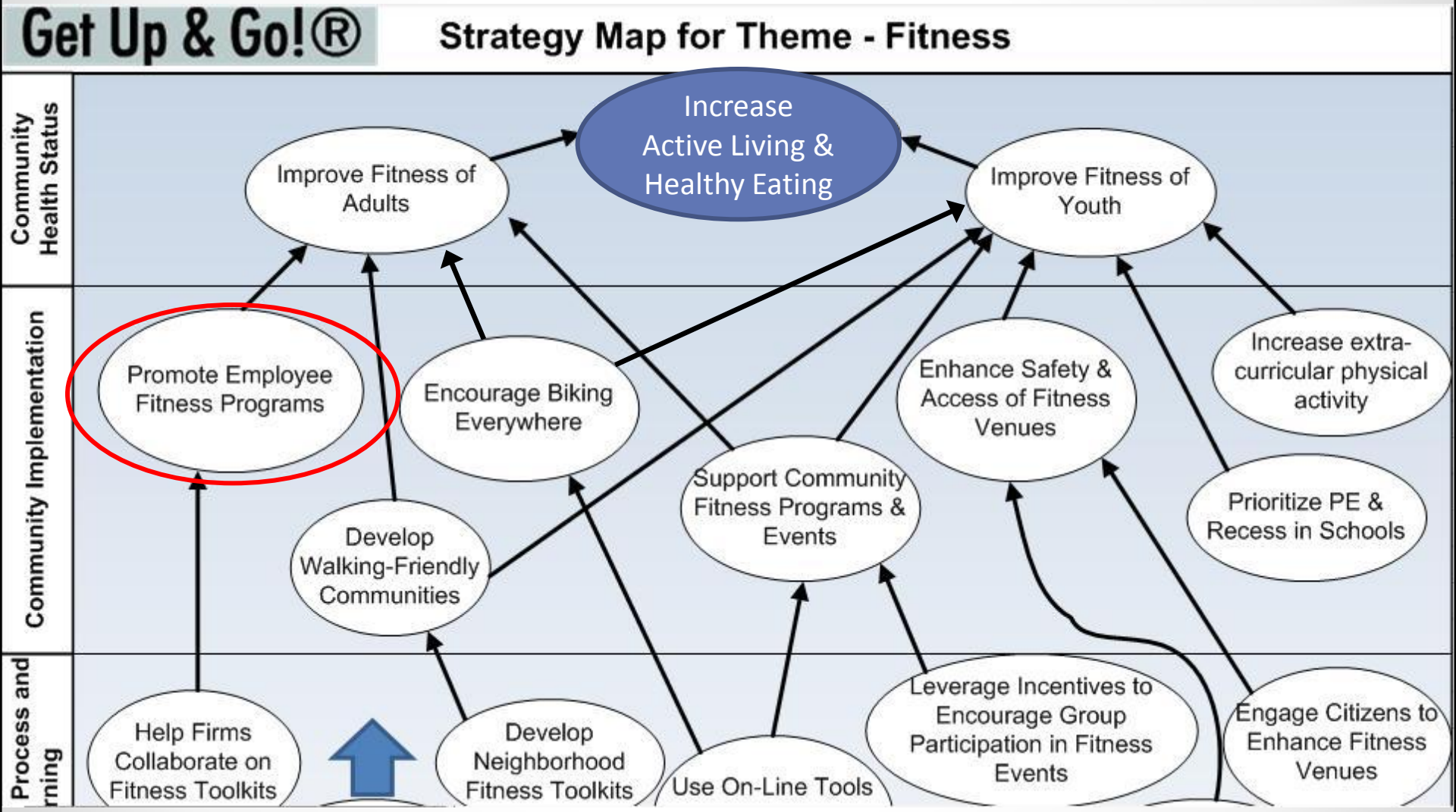
Obj. 1i. By 2012 produce and distribute to local media outlets 4 video and 4 audio public service announcements targeting youth that will convey the importance of healthy eating and active lifestyles.

- Fall 2010 ROEC solicits interest from middle schools regarding media literacy curriculum.
- Schools qualifying for media literacy component, must demonstrate health education curriculum that meets standards or a plan to upgrade curriculum
- Center for Media Literacy provides professional development for middle school teachers & administrators
- Spring 2011 students participate in 5 interactive lessons delivered from Nooview website constructing their own media messages promoting healthy eating and active lifestyles.
- Schools utilize messages to promote healthy eating & active lifestyles to parents, students, teachers, & surrounding community for example, by the school website, billboards or other mechanisms.
- Spring 2011, SC works with schools participating in Media Literacy initiative (in Obj. 1h) for students to enter competition for 4 best commercials"
- Summer 2011 panel of judges considers entries & selects 4 best entries for video & audio production
- Summer 2011 youth go to SIUE Dept of Mass Communication for professional production
- Fall 2011-end of project
- Commercials aired on St. Louis & local media as well as *Get Up & Go!* website and school websites

And from other grant applications and planning documents

A Community Strategy in InsightVision

Zooming in to the Details of Execution



On-line Strategy Management System

INSIGHTVISION

Welcome, Bill Barberg | Help | Logout | Change Password

Home — Start Again | Scoreboard — Data Driven Decisions | Reports — Data & Projects | Strategy Maps — Cause & Effect Logic | Scorecard Builder — Organize Data | Administration — Users, Data Import, Set up

St. Clair County Health Care Commission Strategy Management System

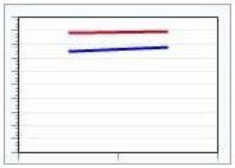
This on-line system is designed to help organizations throughout the county collaborate to improve the overall quality of life of their communities and the health and well-being of our 262,000 citizens. For more information on how your organization can participate in this collaborative process, please contact Mark Peters, Director of Community Health, St. Clair County Health Department by phone at (618) 233-7703, ext 4423 or email at Mark.Peters@co.st-clair.il.us.

For training videos and PDF's of exercises visit the Training Center.

Featured Measures Tablet

Print Select

MATCH: Diabetic screening



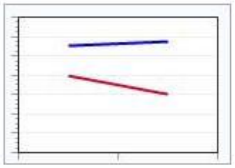
FY2011

78%

Description

What It Is: Diabetic screening is calculated as the percent of diabetic Medicare patients whose blood sugar

GUG T-Fitness: % of Adults who are obese



FY2009

28.6%

Description

From State BRFSS data

GUG T-Fitness: # of Companies with Employee Fitness Programs

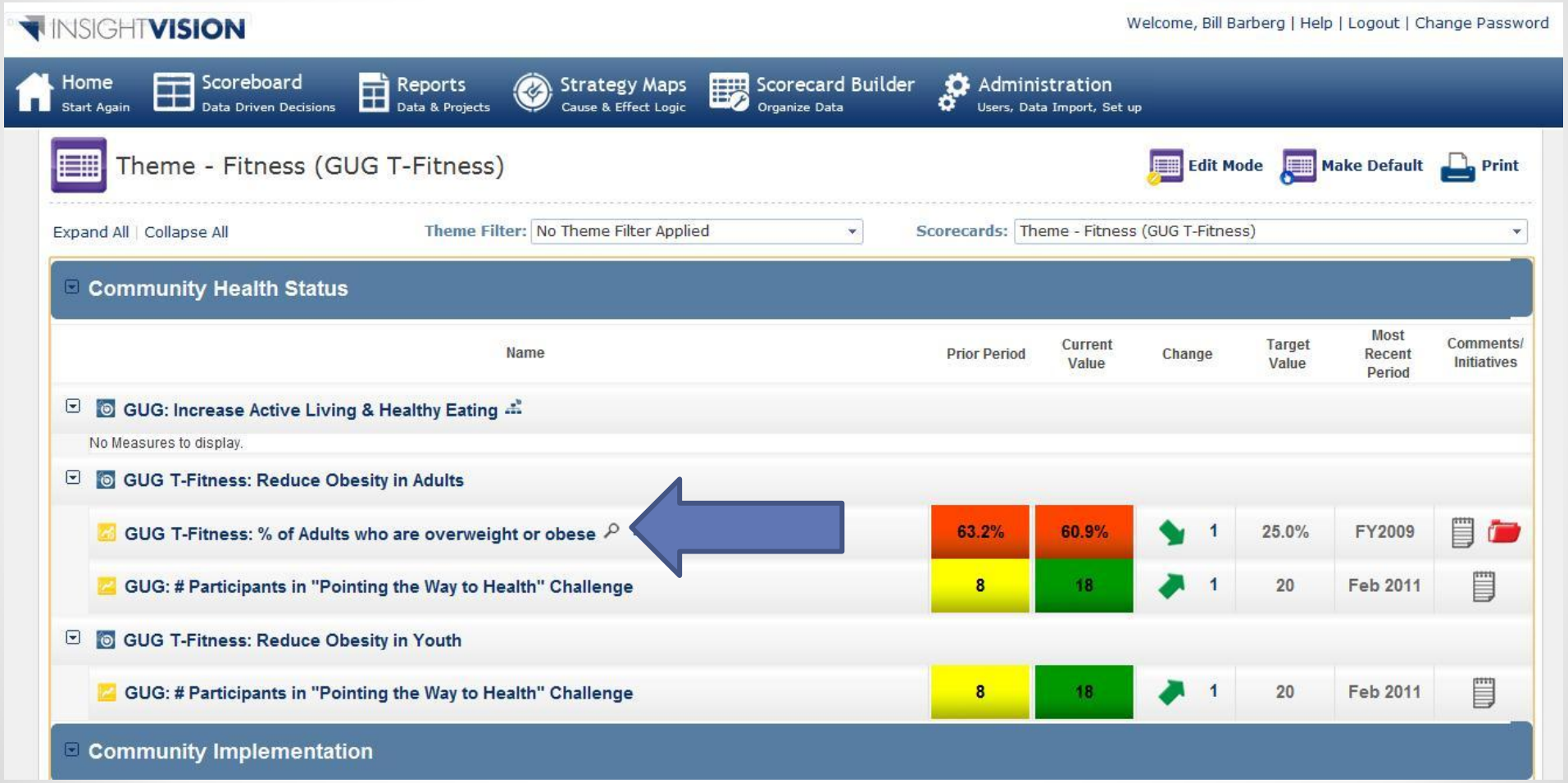
N/A

N/A

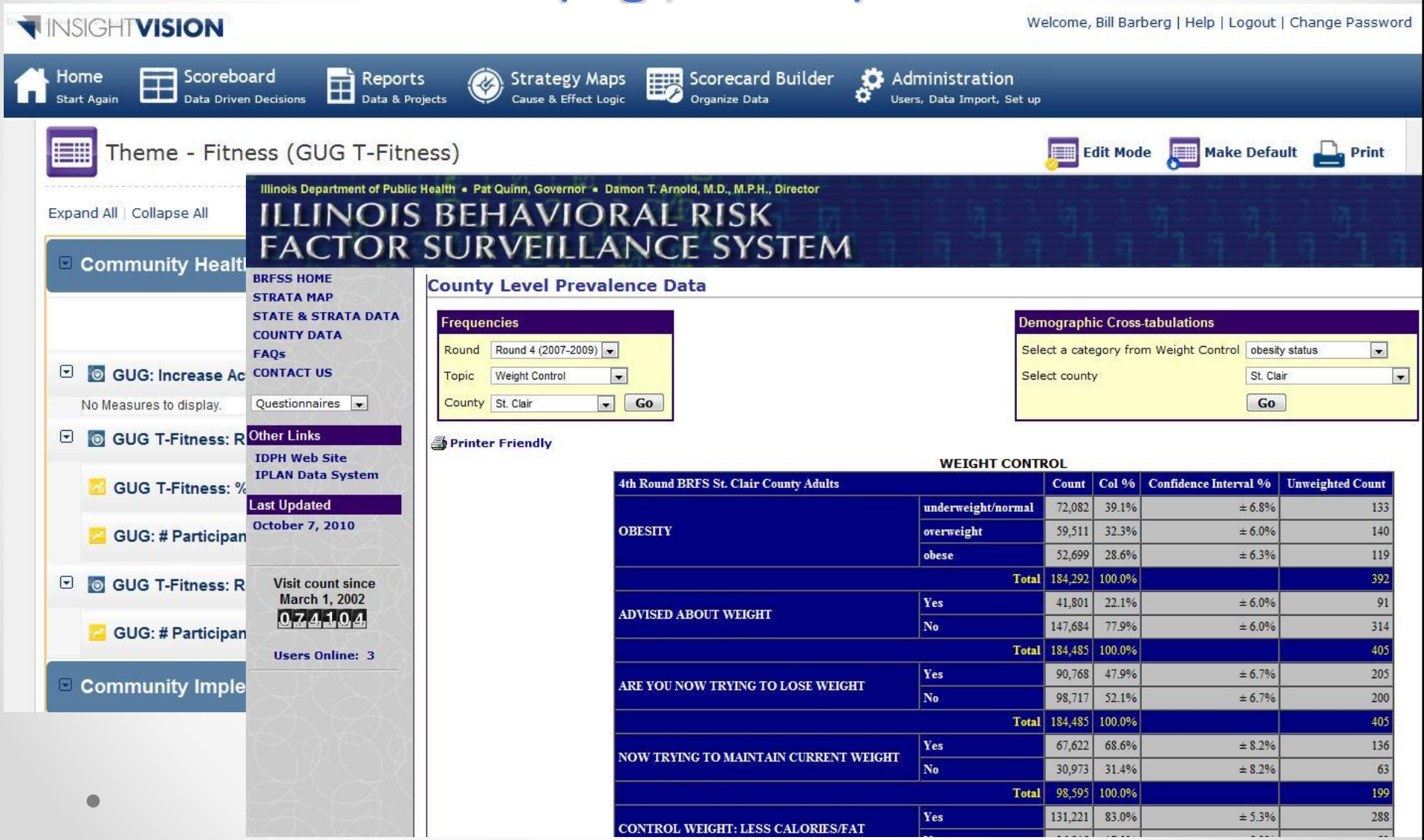
Description

# of Companies with Employee Fitness Programs

Easily Accessing Other Information



One Click Drill-down to Health Assessment Data (e.g., BRFSS)



Objective Present View

P-BRC: Encourage More People to Run More

Print

Description | From - To Gap

Edit

The Belleville Running Club will play a lead role in promoting running as means of getting exercise (especially for new runners and especially in small groups that run together).

The community can rally around the Bellville Running Club as a great resource for people who want to start running or run more consistently, and the BRC will expand their efforts to support runners who need a little extra encouragement.

Wiki Link: Belleville Running Club

Link to Wiki for more details

Measures

Select

P-BRC: Number of active participants in the Beginner Program

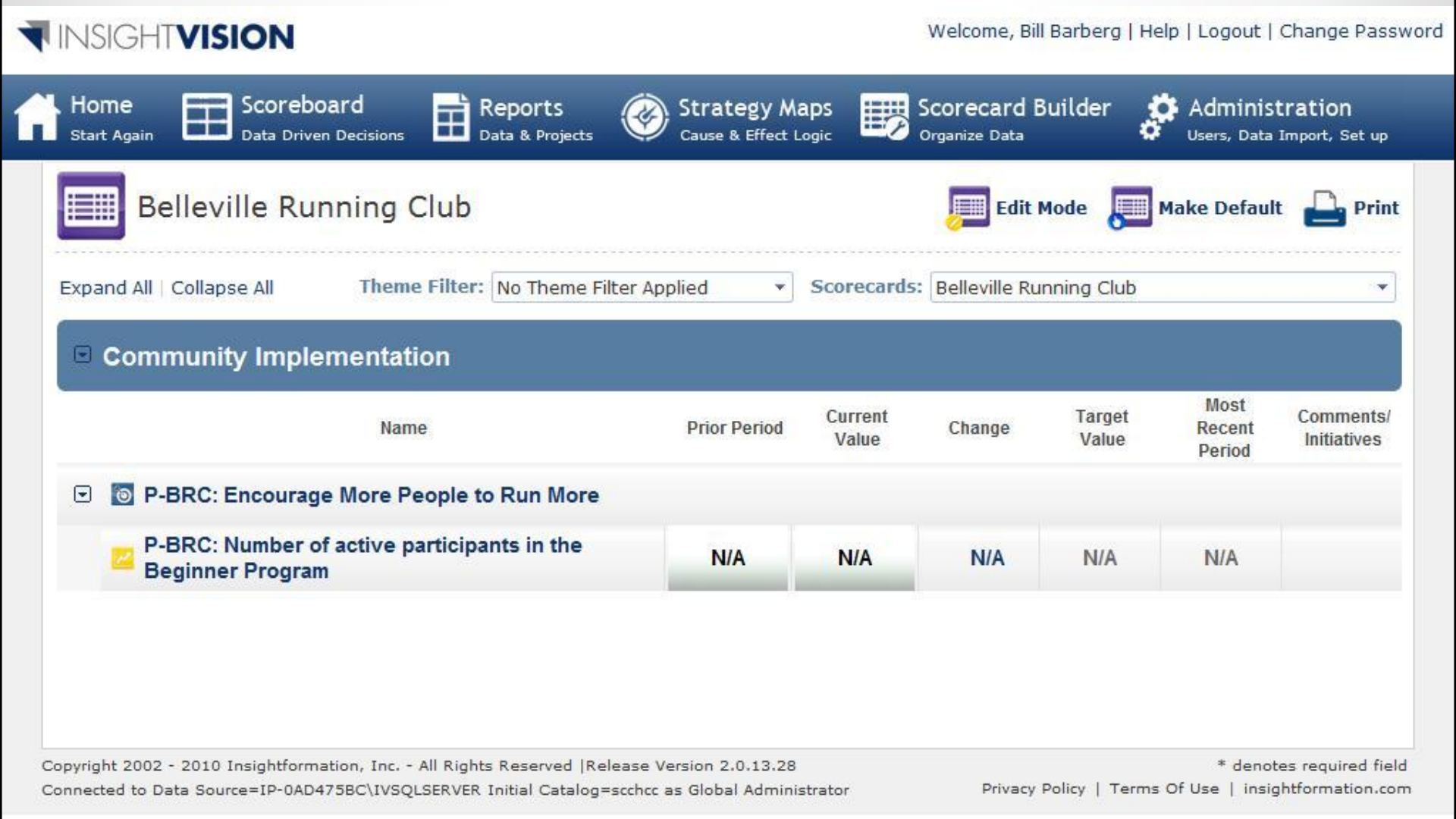
N/A

N/A

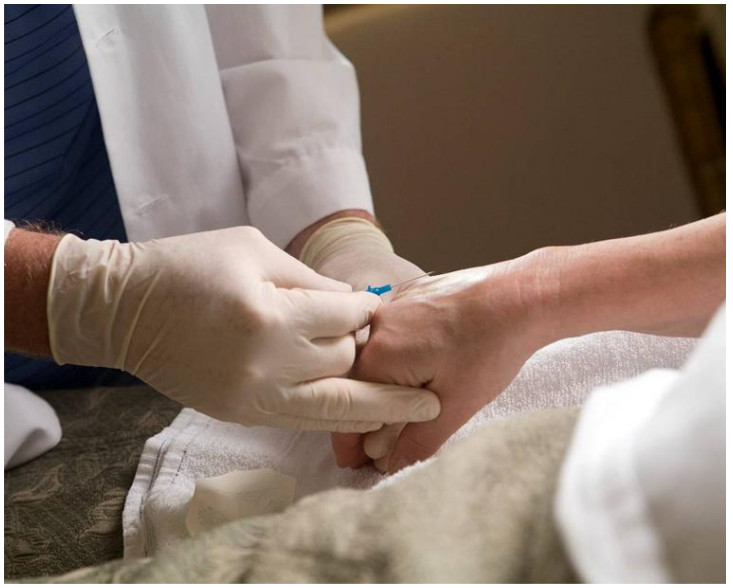
Description

Count of active participants each month.

Visibility to their Objective & Measure



Additional Partnership Projects Underway



Community Benefit Steering Committee

ACA Raises the Bar for Non-Profit Hospitals

The Patient Protection and Affordable Care Act **Section 9007** requires non-profit hospitals to:

(1) conduct a community health needs assessment at least every three years and

(2) adopt an implementation strategy to meet the community health needs identified by the assessment.

The community health needs assessment must include input from persons who represent the broad interests of the community served by the hospital facility…

St. Elizabeth's HOSPITAL

Community Benefit Needs Assessment Process -- 2012

Leede Survey

Health Issues:
- High blood pressure: 62.6%
- High Cholesterol: 54.4%
- Heart Disease24.1%
- Diabetes: 22.9%
- Mental Health issues: 13.1%
- Asthma: 11.4%
- Stroke: 7.6%
- Substance Abuse: 5.8%
- Cancer: 5.5%
- STD: 2.0%

Personal Health Rating:
- 18.4% said poor to fair

Lack Insurance Coverage: 12%

Did not receive needed care
- 6.5% due to cost or no insurance

St. Clair Co IPLAN

Health Issues:
1. Chronic Diseases:
   - Diabetes
   - Heart Disease
   - Lung Cancer & COPD
2. Maternal & Child Health
   - Infant Mortality
   - Teen Pregnancy
   - STD/HIV
3. Behavioral Health
   - Suicide
   - Substance Abuse
4. Violence
   - Homicide
   - Domestic Violence
   - Neighborhood Safety

Other Data Sources

Mo. Hospital Ass. For St. Clair Co:

Preventable hospitalizations:
- CHF
- Bacterial pneumonia
- Diabetes
- COPD

County Health Rankings of 102 counties:

Mortality: 96

Morbidity: 93

Health Factors: 100
- Healthy Behaviors: 101
- Clinical Care: 25
- Social & Economic: 99
- Physical Environment: 64

Catholic Healthcare West:
- Community Need Index

Community Engagement Priorities
1. **Access to Health Care**
   - Clinics for uninsured
   - Lack of PCPs
   - Insurance costs
2. **Education**
   - Healthy living
   - Healthcare resources
   - End of Life
3. **Mental Health/Addictions**
4. **Chronic Issues**
   - Cardiac/Pulmonary
   - Obesity
   - Mother /Child
5. **Services**
   - Geriatric
   - Special needs

Community Engagement Groups
- ID gaps in services
- ID opportunities to improve health of community
- Recommend priorities

Community Benefit Comm.
- Finalizes priorities
- Sets goals for three new/ expanded programs for FY 13

Admin Team
- Reviews priorities

HSHS Community Benefit Committee
- Reviews plans

St. Elizabeth's Board
- Reviews & finalizes Strategic Goals for FY 13

Thank You

Contact Information for Mark Peters

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Email: mark.peters@co.st-clair.il.us

Discussion and Questions

Last Word

The next CHA/CHIP training webinar will be on:

'Choosing Strategies and Tactics for Health Improvement'

Presenter: Marni Mason

Wednesday, 6/13/12 at 2:30 PM ET

Please complete the evaluation before logging off the webinar.