Advisory Board | Population Health Advisor

Ten Tools for Prioritizing Community Health Interventions

How to choose impactful interventions that extend your population health goals

IMPLEMENTATION RESOURCE

- Four steps to set focused community priorities
- Standard scoring template to rank order across various community health needs
- Detailed community health and provider surveys

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Advisors to Our Work

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Source: Population Health Advisor interviews and analysis.

Community-Based Interventions Require Due Diligence

The impact of social factors such as food insecurity, poverty, and transportation on health status is undeniable. Extensive research estimates that up to 20 percent of health outcomes are a result of social and environmental risk factors. To address patients' unmet social needs before an acute care episode, population health managers increasingly extend care model interventions into the community.

While solutions that address social factors are now more common, the traditional healthcare delivery system still struggles to systematically address non-clinical needs. With countless potential challenges to consider and limited available resources, population health managers often find it difficult to determine when and how to implement community-based health efforts. In addition, community-based interventions are frequently ad-hoc, fragmented, and often at the mercy of inconsistent grant funding.

For community-based interventions to be sustainable and effective, they must be as purpose-driven as clinical interventions, well-supported by data and continuously assessed for efficacy. Community engagement starts with leveraging data to identify how to best allocate limited resources. From there, providers can prioritize activities that align to the greatest community needs, community groups, and core population health goals.

This toolkit outlines four steps for focusing on the highest return community health needs: Define core measures, prioritize key activities, create formal partnership compacts, and evaluate performance of community-based interventions. Each step is supported by sample resources including surveys, prioritization tools, and metric pick lists.

Three Challenges Limiting Success of Community-Based Interventions

An Overwhelming Set of Opportunities to Pursue

System investment in interventions is haphazard, based on pick-and-choose of myriad options

Current Efforts Ad-Hoc Passion Projects

Passion projects are steered by individual stakeholders rather than data-informed approach

Limited Funding Precludes Comprehensive Approach

Even the most thoughtfully-designed programs struggle with inconsistent funding

Source: Population Health Advisor interviews and analysis.

Four Steps to Focusing Community-Based Priorities

1 Define core measures

Associated Tools
- Checklist for gathering comprehensive qualitative input
- Sample scripting for survey outreach
- Qualitative provider, community member surveys

2 Prioritize by improvement opportunity, resource burden

Associated Tools
- Quick reference to determine value-based impact of inflecting non-clinical needs
- Initiative scoring template
- Initiative decision guide

3 Create partnership compacts

Associated Tools
- Community partner brainstorming guide
- Sample memorandum of understanding

4 Evaluate short- and long-term performance

Associated Tools
- Metric evaluation guide
- Metric picklist for assessing community-based interventions

Source: Population Health Advisor interviews and analysis.

Step

1

Define Your Core Measures

Define Your Core Measures

Size Community Gaps Using Already Aggregated Data from CHNAs[1]

When choosing community-based interventions, it is essential to focus on activities that will be most important for improving community health. To accomplish this, the first step is to define a set of measures that capture an organization's targeted health priorities to track. Providers determine core measures by using quantitative data to understand community trends, gathering qualitative information to surface key gaps in community health, and mapping important measures to population health focus areas. Providers gather qualitative data by talking to internal organizational leaders and surveying community members and organizations.

For most organizations, the community health needs assessment offers the best staring point for analyzing both non-clinical and clinical care gaps in your market. The CHNA aggregates information about population demand, resource gaps, existing community asset allocation, and potential community partners. Most CHNAs include the quantitative data you need to start the process of defining your core community health measures. For CHNA's more than a year old, providers should gather new qualitative data through targeted surveys, interviews, or community forums.

This section includes tools to help providers set core measures for monitoring community health, including:

- A checklist for gathering comprehensive qualitative input
- Sample scripting for survey outreach
- Qualitative provider and community member stakeholder surveys

1) Community health needs assessments (CHNAs) are required under the Affordable Care Act only for tax-exempt provider organizations and help all health care providers clarify community challenges that impact care quality and utilization.

Source: Population Health Advisor interviews and analysis.

A Judicious Approach to Selecting Key Metrics

Case in Brief: Adventist HealthCare

- Four-hospital, nonprofit health system based in Montgomery County, Maryland
- Adventist HealthCare is a contributing organization to Healthy Montgomery, the Local Health Improvement Coalition (LHIC), which is led by Montgomery County Health and Human Services; members include the six local nonprofit hospitals and a range of community stakeholders (e.g., county government agencies, county minority health programs/initiatives, advocacy groups, academic institutions, community-based service providers)
- Adventist HealthCare pairs the range of quantitative and qualitative data collected by Healthy Montgomery with input from community stakeholders and members to build a comprehensive community health needs assessment

Multidimensional Community Health Needs Assessment Process Informs Population Health Strategy

In order to make strategic community health improvement investments, each Adventist HealthCare hospital conducts a multidimensional community health needs assessment. Adventist starts with a four-pronged quantitative and qualitative data gathering approach to build a foundation of information at the system level. Assessments are completed for each hospital's Community Benefit Service Area (CBSA), defined as the ZIP codes that make up the top 85% of patient discharges. Adventist collects ZIP code-level data from surveys directed to community members and obtains county-level data from Healthy Montgomery (e.g., database, focus groups) and other public records.

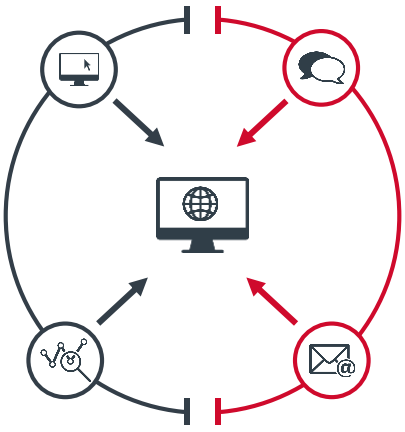
Collects Quantitative Data

1 Healthy Montgomery data set

- Funded by Adventist HealthCare and three other health care systems[1]—Holy Cross Health, MedStar Montgomery Medical Center, and Suburban Hospital—to centralize health-related data and coordinate local efforts to address health needs and disparities
- Consists of federal, state, and local data sources (e.g., census data, American Community Survey)
- Provides accessible, user-friendly data across 100 metrics, including 37 pertaining to the county's six priority areas[2]
- Includes data on social determinants of health, such as families living below the poverty level, students receiving free or reduced-price meals

2 Government public records

Gather data from U.S. Census Bureau (American Community Survey), Centers for Disease Control and Prevention, National Cancer Institute, Maryland State Health Improvement Process, Maryland Behavioral Risk Factor Surveillance System, and others



Gathers Qualitative Input

3 Community Health and Wellness Advisory Board

- Consists of 18 participants, including county government representatives, local minority health initiatives, universities, and leaders from local community based health care organizations
- Serves as community expert panel, helping to identify priority areas, existing services, and service gaps

4 Patients, community members

- Provide individual input in person (e.g., in hospital, in partner community-based organizations), through online surveys
  - Across the system, 1,349 survey responses were gathered over the course of five months from in-person, email, and social media outreach (e.g., Facebook, Twitter)
  - Adventist HealthCare offered incentives to participants to increase response rates (e.g., raffle for iPad Mini, gift cards)
- Participate in 15 different open-access focus groups (e.g., youth, seniors, people with disabilities, Latino community) led by Healthy Montgomery

1) Each hospital contributes $25,000 yearly to its operations.
2) Healthy Montgomery's 37 core measures are listed on the previous page 10.

Source: "Community Health Needs Assessment," Adventist HealthCare, https://www.adventisthealthcare.com/about/community/health-needs-assessment/#Washington-Adventist-Hospital; Population Health Advisor interviews and analysis.

Restrict the Number of Tracked Metrics

Healthy Montgomery Picks 37 Core Measures for Ongoing Data Monitoring

Cross-cutting measures

- Adults who have had a routine check-up
- Persons without health insurance
- Adults in good physical health
- Adults in good mental health
- Students in good general health
- Students ever feeling sad or hopeless in past year
- Adults who smoke
- Students current cigarette use

Social determinants of heath

- Families living below poverty level
- Residents 5+ years old that report speaking English “not very well”
- Students ever receiving Free And Reduced-price Meals (FARM)
- Adults with adequate social and emotional support
- Students who could talk to adult besides a parent
- Student participation in extracurricular activities
- High school completion rate

Obesity

- Adults engaging in moderate physical activity
- Adult fruit and vegetable consumption
- Adults who are overweight or obese
- Students with no participation in physical activity
- Students who drank no soda or pop in the past week
- Students who are overweight or obese

Behavioral health

- Adolescent and adult illicit drug use in past month
- Adults with any mental illness in past year
- ER visits for behavioral health
- Suicide

Cancers

- Colorectal screening
- Pap smear test in past 3 years
- Prostate cancer incidence
- Breast cancer mortality

Maternal and infant health

- Mothers who received early prenatal care
- Infant mortality
- Babies with low birthweight

Diabetes

- Adults with diabetes
- ER visits for diabetes

Cardiovascular health

- Heart disease mortality
- Stroke mortality
- High blood pressure prevalence

Source: Healthy Montgomery, Montgomery County, MD; Population Health Advisor interviews and analysis.

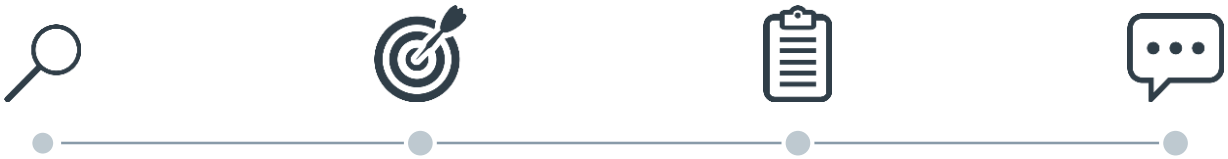
Prioritize Stakeholder Outreach to Gather Qualitative Intel

Update CHNA Data with Input from Experts, Community Representatives

The CHNA may not give providers all the information needed to prioritize non-clinical and clinical community care gaps. The easiest way to round out an analysis of community health gaps is through targeted information surveys, community forums, and/or interviews with stakeholders that have firsthand knowledge gaps in their respective communities.

While there are a wide range of possible stakeholders to engage, prioritize outreach to those most likely to have high-level perspectives of broad community needs. Ask stakeholders to choose only a few focus areas across key needs and the range of possible community-based interventions.

Four Steps to Gather Qualitative Data on Community Health Priorities



Identify organizations and groups for outreach

- Categorize organizations
- Identify organizations with the biggest community reach
- Select multiple stakeholders per organization to ensure representation

Prioritize outreach to those with deep community knowledge

- Use existing relationships to increase likelihood of participation
- Reach out to organization leaders with high-level perspectives

Gather and centralize contact information for easy access

- Assign responsibility of database management with main points of contact
- Tap into existing, knowledgeable staff (e.g., community resource specialists)

Develop and disseminate templated outreach materials

- Strategize outreach method based on preferred modes of communication by each community segment
- Set clear time frame for data collection

Checklist to identify methods and community groups for qualitative input on p. 12

Sample outreach scripting to encourage individuals to partake in assessment on p. 13

Invite Diverse Set of Key Stakeholders for 360-Degree View

Since providers have to build upon already aggregated data, While aggregated data is the best starting place, targeted outreach helps providers contextualize data by finding root causes of community gaps and alerts stakeholders that the provider is interested in new collaborations.

The intel gathering process can take a lot of time, so it is important to get input at scale. Use the following checklist to determine the best methods to gather feedback and identify which community stakeholders to engage.

Qualitative Data Pick List

Strategize Data Gathering Methods

Reach Out to Community Members and Organizations

Use scalable approach to gather feedback about health needs and service gaps

- ❑ Focus groups
- ❑ Surveys via social media
- ❑ Phone-based and in-person interviews
- ❑ Open access community advisory meetings/forums

Members: Get input from major subpopulations to capture diverse community health needs

- ❑ Patients
- ❑ Employees
- ❑ Age groups
- ❑ Race/ethnic groups
- ❑ Faith communities
- ❑ Underrepresented demographic groups

Organizations: Get input from health and community organization leaders to represent diverse local interests

- ❑ Primary care providers
- ❑ Behavioral health providers
- ❑ Other health systems
- ❑ Health plans
- ❑ Health advocacy organizations[1]
- ❑ Community health centers
- ❑ Nonprofit organizations[2]
- ❑ Religious organizations
- ❑ Major local businesses
- ❑ School systems[3]
- ❑ Law enforcement
- ❑ Local government

Sample Data Points to Collect Across Qualitative Assessments

Demographics

- Age
- Education level

Community Heath Needs

- Prevalence of social determinants of health
- Social service availability

Health Status

- Mental and physical health
- Prevalence of chronic conditions

Care Access

- Ability to visit doctor when sick
- Number of preventive care services utilized

1) Special-interest groups focused on veterans, immigrants, and people experiencing homelessness.
2) Common organizations include the YMCA, Meals on Wheels, and Head Start.
3) Including the K-12 public school system and higher education.

Source: Population Health Advisor interviews and analysis.

Thoughtful Administration Gives Your Survey a Boost

For organizations to get robust qualitative feedback, it is important to have good response rates. Providers can boost response rates by deploying tactics that personalize outreach and make the process easy for the receiver.

For in-person outreach, incentivizing people with a raffle that includes prizes or other perks can help. For virtual outreach, communication should incorporate the level of effort required, state the goal of a survey or activity, and potentially come from someone the receiver knows. Baptist Health Medical Group in Coral Gables, Florida uses these tactics to raise participation in telephonic and online surveys.

Baptist Health Medical Group's Best Practices for Engaging Targeted Participants in Surveys

1. Introduce the survey in person, so participants don't think the email is spam
2. Put the estimated amount of time it takes to complete the survey in the subject line
3. Ground the email in a mission statement, so readers know why they should take part
4. Reiterate that the survey will take only a few minutes of time in the body scripting
5. Consider making the survey anonymous to encourage honest answers

Sample Survey Invitation Scripting

Dear [Target Group],

As mentioned in our conversation on [Date], I am writing from [Organization] to gather your input in order to address major health needs and challenges in [Location].

Please fill out this BRIEF questionnaire so we can better understand how to meet your needs as a valued member of our community. We'd love to learn about the health status of the individuals you serve, your perception of access to care, and your satisfaction with the quality of care your constituency experiences. Your responses will be strictly anonymous so please be as honest as possible.

Thanks again,
[Name]

Source: Paul Di Capua, Baptist Health Medical Group; Population Health Advisor interviews and analysis.

Force Priorities in Qualitative Intel Gathering

Every community has a broad set of needs that can affect the health status of community members. To identify the most pressing needs to target with community programming, direct informants to choose only a small subset of the most important ones during the survey process.

Leading population health organizations, such as Montefiore Medical Center in the Bronx, force trade-offs when surveying community partners on health care needs. As part of their community health needs assessment, they conduct a survey to gather feedback from key subpopulations and to identify existing initiatives across health-related community groups. Montefiore asks respondents to select only three targets across comprehensive lists of health concerns, intervention activities, and barriers to service provision. This helps isolate the key "to-dos" in the community and identify themes across respondents. The health center distributes the survey in five languages[1] to boost response rates across diverse perspectives.

Explains the survey's purpose

Identifies stakeholder's target population

Requires stakeholder to force trade-offs across needs

BRONX PARTNERS FOR HEALTHY COMMUNITIES

BRONX COUNTY PROVIDER SURVEY

We want to hear your thoughts about important health issues in the community you serve. Together, the county health department and hospitals throughout Bronx County, NY will use the results of this short survey and other information to help improve health programs. Thank you for your participation!

Please check the categories that best describe your agency. *(Please check all that apply)*

- ☐ Community-based Organization
- ☐ Community Health Center
- ☐ Dental Practice
- ☐ Home Care Agency
- ☐ Hospital
- ☐ Medical Practice
- ☐ Mental Health Clinic
- ☐ Outpatient Clinic
- ☐ Other *(please specify)*: _____

Please check the types of services provided by your agency. *(Please check all that apply)*

- ☐ Breastfeeding support
- ☐ Dental services
- ☐ Childcare
- ☐ Community education
- ☐ Domestic violence prevention
- ☐ Drug/alcohol services
- ☐ Elder care/senior services
- ☐ Exercise/ weight loss programs
- ☐ Family Planning
- ☐ Health insurance enrollment
- ☐ Health screenings
- ☐ Home care services
- ☐ Immigrant support services
- ☐ Mental health services
- ☐ Prenatal/PCAP services
- ☐ Primary care services- adults
- ☐ Primary care services- children
- ☐ Smoking/tobacco services
- ☐ Transportation
- ☐ Violence/bullying/gang prevention
- ☐ WIC
- ☐ Other *(please specify)*: _____

Please check all persons served by your agency. *(Check all that apply)*

- ☐ Adults
- ☐ Children
- ☐ Disabled
- ☐ Immigrants
- ☐ Low-income
- ☐ Other *(please specify)*: _____
- ☐ Uninsured

What are the THREE biggest ongoing health concerns for the people/community you serve?

- ☐ Access to primary health care
- ☐ Access to specialty care
- ☐ Alcohol abuse
- ☐ Asthma/breathing problems
- ☐ Cancer
- ☐ Care for the elderly
- ☐ Child health & wellness
- ☐ Dementia/Alzheimer's
- ☐ Dental care
- ☐ Diabetes
- ☐ Disability
- ☐ Distracted driving
- ☐ Drug abuse
- ☐ Family planning/teen pregnancy
- ☐ Healthy environment
- ☐ Heart disease/stroke
- ☐ HIV/AIDS & Sexually Transmitted Infections
- ☐ Mental health/depression/suicide
- ☐ Nutrition/eating habits
- ☐ Overweight/obesity
- ☐ Preventable injury/falls
- ☐ Smoking/tobacco use
- ☐ Violence
- ☐ Women's health
- ☐ Other: *(please specify)* _____

What THREE things would be most helpful to improve health problems of the people/community you serve?

- ☐ Access to healthier food
- ☐ Affordable housing
- ☐ Breastfeeding support
- ☐ Caregiver support
- ☐ Clean air & water
- ☐ Community education
- ☐ Dental services
- ☐ Domestic violence prevention
- ☐ Drug/alcohol services
- ☐ Elder care services
- ☐ Exercise/weight loss programs
- ☐ Health Insurance enrollment
- ☐ Health screenings
- ☐ Home care services
- ☐ Immigrant support services
- ☐ Job opportunities
- ☐ Mental health services
- ☐ Safer childcare options
- ☐ Safer places to walk/play
- ☐ Smoking/tobacco services
- ☐ Transportation
- ☐ Violence/bullying/gang prevention
- ☐ Other *(please specify)*: _____

How would you rate the health of the people/community you serve?

☐ Very healthy ☐ Healthy ☐ Somewhat healthy ☐ Unhealthy ☐ Very unhealthy

Source: "Community Health Needs Assessment and Implementation Plan 2016-2018, Montefiore Medical Center," https://www.montefiore.org/documents/communityservices/Community-Health-Needs-Assessment-MMC.pdf; Population Health Advisor interviews and analysis.

1) English, Spanish, Arabic, French Creole, and Chinese.

Montefiore's Provider Survey, Part 1

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We want to hear your thoughts about important health issues in the community you serve. Together, the county health department and hospitals throughout Bronx County, NY will use the results of this short survey and other information to help improve health programs. Thank you for your participation!

Please check the categories that best describe your agency. *(Please check all that apply)*

- ☐ Community-based Organization
- ☐ Community Health Center
- ☐ Dental Practice
- ☐ Home Care Agency
- ☐ Hospital
- ☐ Medical Practice
- ☐ Mental Health Clinic
- ☐ Outpatient Clinic
- ☐ Other *(please specify)*: _____

Please check the types of services provided by your agency. *(Please check all that apply)*

- ☐ Breastfeeding support
- ☐ Dental services
- ☐ Childcare
- ☐ Community education
- ☐ Domestic violence prevention
- ☐ Drug/alcohol services
- ☐ Elder care/senior services
- ☐ Exercise/ weight loss programs
- ☐ Family Planning
- ☐ Health insurance enrollment
- ☐ Health screenings
- ☐ Home care services
- ☐ Immigrant support services
- ☐ Mental health services
- ☐ Prenatal/PCAP services
- ☐ Primary care services- adults
- ☐ Primary care services- children
- ☐ Smoking/tobacco services
- ☐ Transportation
- ☐ Violence/bullying/gang prevention
- ☐ WIC
- ☐ Other *(please specify)*: _____

Please check all persons served by your agency. *(Check all that apply)*

- ☐ Adults
- ☐ Children
- ☐ Disabled
- ☐ Immigrants
- ☐ Low-income
- ☐ Other *(please specify)*: _____
- ☐ Uninsured

What are the THREE biggest ongoing health concerns for the people/community you serve?

- ☐ Access to primary health care
- ☐ Access to specialty care
- ☐ Alcohol abuse
- ☐ Asthma/breathing problems
- ☐ Cancer
- ☐ Care for the elderly
- ☐ Child health & wellness
- ☐ Dementia/Alzheimer's
- ☐ Dental care
- ☐ Diabetes
- ☐ Disability
- ☐ Distracted driving
- ☐ Drug abuse
- ☐ Family planning/teen pregnancy
- ☐ Healthy environment
- ☐ Heart disease/stroke
- ☐ HIV/AIDS & Sexually Transmitted Infections
- ☐ Mental health/depression/suicide
- ☐ Nutrition/eating habits
- ☐ Overweight/obesity
- ☐ Preventable injury/falls
- ☐ Smoking/tobacco use
- ☐ Violence
- ☐ Women's health
- ☐ Other: *(please specify)* _____

What THREE things would be most helpful to improve health problems of the people/community you serve?

- ☐ Access to healthier food
- ☐ Affordable housing
- ☐ Breastfeeding support
- ☐ Caregiver support
- ☐ Clean air & water
- ☐ Community education
- ☐ Dental services
- ☐ Domestic violence prevention
- ☐ Drug/alcohol services
- ☐ Elder care services
- ☐ Exercise/weight loss programs
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- ☐ Job opportunities
- ☐ Mental health services
- ☐ Safer childcare options
- ☐ Safer places to walk/play
- ☐ Smoking/tobacco services
- ☐ Transportation
- ☐ Violence/bullying/gang prevention
- ☐ Other *(please specify)*: _____

How would you rate the health of the people/community you serve?

☐ Very healthy ☐ Healthy ☐ Somewhat healthy ☐ Unhealthy ☐ Very unhealthy

Source: "Community Health Needs Assessment and Implementation Plan 2016-2018, Montefiore Medical Center," https://www.montefiore.org/documents/communityservices/Community-Health-Needs-Assessment-MMC.pdf; Population Health Advisor interviews and analysis.

Montefiore's Provider Survey, Part 2

What are the THREE most significant barriers impacting YOUR ability to provide services to your patients/clients?

- ☐ Cultural competency issues
- ☐ High no-show rate
- ☐ Inadequate insurance reimbursement
- ☐ Lack of funding
- ☐ Limited bi-lingual staff
- ☐ Limited or lack of access to specialists
- ☐ Limited space and/or equipment
- ☐ Limited staffing resources
- ☐ Patient cannot afford prescription meds
- ☐ Patient non-adherence to treatment
- ☐ Other *(please specify)*: _____

For the patients/clients you serve, what are the top THREE barriers impacting your clients' ability to access services?

- ☐ There are no issues
- ☐ Cannot afford services
- ☐ Co-pay/deductible too high
- ☐ Cultural/religious beliefs
- ☐ Don't like going/afraid to go
- ☐ Don't understand need to see a provider
- ☐ Inconvenient office hours
- ☐ Insurance does not cover service
- ☐ Lack of time
- ☐ Lack or limited providers/service
- ☐ Lack or limited providers who speak their language
- ☐ No transportation/too far
- ☐ No childcare
- ☐ No insurance
- ☐ Other *(please specify)*: _____

Where do community members you serve get most of their health information? *(Check all that apply)*

- ☐ Community-based organization
- ☐ Doctor/Health professional
- ☐ Family or friends
- ☐ Health department
- ☐ Hospital
- ☐ Internet
- ☐ Library
- ☐ Newspaper/magazine
- ☐ Radio
- ☐ Religious organization
- ☐ School/college
- ☐ Social media *(Facebook, Twitter, etc.)*
- ☐ Television
- ☐ Worksite
- ☐ Other *(please specify)*: _____

For statistical purposes only, (your responses are anonymous) please complete the following:

Zip code where you work: _____

How would you best describe your title/role in your agency?

- ☐ Advocate
- ☐ Alcohol/substance counselor
- ☐ Board member
- ☐ Dentist
- ☐ Executive director
- ☐ Health educator
- ☐ Nurse
- ☐ Physician
- ☐ Program administrator/manager
- ☐ Psychologist
- ☐ Social worker
- ☐ Other: _____

Optional

Your name: _____ **Phone # :** _____

Title: _____ **Agency:** _____

Email address: _____

Source: "Community Health Needs Assessment and Implementation Plan 2016-2018, Montefiore Medical Center," https://www.montefiore.org/documents/communityservices/Community-Health-Needs-Assessment-MMC.pdf; Population Health Advisor interviews and analysis.

Montefiore's Community Health Survey, Part 1

BRONX PARTNERS FOR HEALTHY COMMUNITIES

BRONX COUNTY COMMUNITY HEALTH SURVEY

We want to hear your thoughts about important health issues in your community. Together, the county health department and hospitals throughout Bronx County, NY will use the results of this short survey and other information to help improve health programs in your community. Your responses are completely anonymous. Thank you for your participation!

What are the THREE biggest ongoing health concerns in the COMMUNITY WHERE YOU LIVE?

- ☐ Access to primary care
- ☐ Alcohol abuse
- ☐ Asthma/breathing problems
- ☐ Cancer
- ☐ Care for the elderly
- ☐ Child health & wellness
- ☐ Dementia/Alzheimer's
- ☐ Dental care
- ☐ Diabetes
- ☐ Disability
- ☐ Distracted driving
- ☐ Drug abuse
- ☐ Family planning/teen pregnancy
- ☐ Healthy environment
- ☐ Heart disease/stroke
- ☐ HIV/AIDS & Sexually Transmitted Infections
- ☐ Other: _____
- ☐ Mental health/depression/suicide
- ☐ Nutrition/eating habits
- ☐ Overweight/obesity
- ☐ Smoking/tobacco use
- ☐ Preventable injury/falls
- ☐ Violence
- ☐ Women's health

What are the THREE biggest ongoing health concerns for YOURSELF?

- ☐ Access to primary care
- ☐ Alcohol abuse
- ☐ Asthma/ breathing problems
- ☐ Cancer
- ☐ Care for the elderly
- ☐ Child health & wellness
- ☐ Dementia/Alzheimer's
- ☐ Dental care
- ☐ Diabetes
- ☐ Disability
- ☐ Distracted driving
- ☐ Drug abuse
- ☐ Family planning/teen pregnancy
- ☐ Healthy environment
- ☐ Heart disease/stroke
- ☐ HIV/AIDS & Sexually Transmitted Infections
- ☐ Other: _____
- ☐ Mental health/depression/suicide
- ☐ Nutrition/eating habits
- ☐ Overweight/obesity
- ☐ Smoking/tobacco use
- ☐ Preventable injury/falls
- ☐ Violence
- ☐ Women's health

What THREE things would be most helpful to improve YOUR health concerns?

- ☐ Access to dental care
- ☐ Access to healthier food
- ☐ Access to primary care
- ☐ Affordable housing
- ☐ Breastfeeding support
- ☐ Caregiver support
- ☐ Clean air & water
- ☐ Community education
- ☐ Domestic violence prevention
- ☐ Drug/alcohol services
- ☐ Elder care services
- ☐ Exercise/weight loss programs
- ☐ Health Insurance enrollment
- ☐ Health screenings
- ☐ Home care services
- ☐ Immigrant support services
- ☐ Job opportunities
- ☐ Mental health services
- ☐ Safer childcare options
- ☐ Safer places to walk/play
- ☐ Smoking/tobacco services
- ☐ Transportation
- ☐ Violence/bullying/gang prevention
- ☐ Other: _____

Do you have a health care provider for checkups and visits? ☐ Yes ☐ No

How would you describe your overall health?

☐ Very healthy ☐ Healthy ☐ Somewhat healthy ☐ Unhealthy ☐ Very unhealthy

How would you describe your overall mental health?

☐ Very healthy ☐ Healthy ☐ Somewhat healthy ☐ Unhealthy ☐ Very unhealthy

Do you suffer from any chronic health conditions? *(Check all that apply)*

- ☐ Asthma/breathing problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Disability
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Mental health
- ☐ Overweight/obesity
- ☐ Drug/alcohol abuse
- ☐ Other: _____

Source: "Community Health Needs Assessment and Implementation Plan 2016-2018, Montefiore Medical Center," https://www.montefiore.org/documents/communityservices/Community-Health-Needs-Assessment-MMC.pdf; Population Health Advisor interviews and analysis.

Montefiore's Community Health Survey, Part 2

How long has it been since you visited a health care provider for a routine physical exam or check-up?

- ☐ In the past year
- ☐ In the past 2 years
- ☐ In the past 5 years
- ☐ 5 or more years ago
- ☐ Never
- ☐ Don't know

What THREE things prevent YOU from getting medical care from a health care provider?

- ☐ Nothing prevents me from getting medical care
- ☐ Cannot afford
- ☐ Cannot find a health provider who speaks my language
- ☐ Co-pay/deductible too high
- ☐ Cultural/religious beliefs
- ☐ Doctor's office not open
- ☐ Don't know how to find providers
- ☐ Don't like going/afraid to go
- ☐ Don't understand need to see a provider
- ☐ I have no time
- ☐ Insurance does not cover service
- ☐ No transportation/too far
- ☐ No childcare
- ☐ No insurance
- ☐ Other: _____

In the past 12 months, did you receive care in the emergency room? ☐ Yes ☐ No

If yes, what is the ONE main reason for your emergency room visit?

- ☐ Could not find a local provider who speaks my language
- ☐ Doctor's office not open
- ☐ Emergency room is the closest provider
- ☐ Health provider said go to emergency room
- ☐ No other place to go
- ☐ Receive most of my care at emergency room
- ☐ Thought problem too serious for a doctor's visit
- ☐ Other: _____

Where do you and your family get most of your health information? (Check all that apply)

- ☐ Community-based organization
- ☐ Doctor/Health professional
- ☐ Family or friends
- ☐ Health department
- ☐ Hospital
- ☐ Internet
- ☐ Library
- ☐ Newspaper/magazine
- ☐ Radio
- ☐ Religious organization
- ☐ School/college
- ☐ Social media (Facebook, Twitter, etc.)
- ☐ Television
- ☐ Worksite
- ☐ Other: _____

For statistical purposes only (your responses are anonymous) please complete the following:

I identify as: ☐ Male ☐ Female ☐ Other

Zip code where I live: _____ **Town/city where I live:** _____

What is your age? ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65-74 ☐ 75+

Are you Hispanic or Latino? ☐ Yes ☐ No

What category best describes your race?

- ☐ White/Caucasian
- ☐ Black/African-American
- ☐ American Indian/Alaskan Native
- ☐ Asian/Pacific Islander
- ☐ Multi-racial
- ☐ Other: _____

What is the primary language you speak?

- ☐ English
- ☐ Spanish
- ☐ Italian
- ☐ Portuguese
- ☐ French
- ☐ Chinese
- ☐ Tagalog
- ☐ Other: _____
- ☐ Korean

What is your highest level of education?

- ☐ Less than high school
- ☐ High school grad/GED
- ☐ Technical school
- ☐ Some college
- ☐ College graduate
- ☐ Other: _____
- ☐ Advanced degree

What is your current employment status?

- ☐ Employed
- ☐ Not Employed
- ☐ Student
- ☐ Military
- ☐ Retired

Do you have any of the following types of health insurance?

- ☐ Medicare
- ☐ Medicaid
- ☐ Private insurance
- ☐ Tri-Care
- ☐ None/no insurance
- ☐ Insurance through NY State or Federal Health Exchange
- ☐ Other: _____

Source: "Community Health Needs Assessment and Implementation Plan 2016-2018, Montefiore Medical Center," https://www.montefiore.org/documents/communityservices/Community-Health-Needs-Assessment-MMC.pdf; Population Health Advisor interviews and analysis.

Step

2

Prioritize by Improvement Opportunity, Resource Demand

Prioritize Improvement Opportunities to Determine Final Focus

Tracking core measures will likely highlight several community health challenges. Providers typically end up with a list of 10 to 12 priorities—still too many to address at the same time. Population health managers need to further prioritize the list of challenges by comparing size of the improvement opportunity with availability of resources to address those needs.

Providers that serve multiple populations, geographies, and service areas should employ an analytic framework that applies a consistent scoring methodology. This framework ensures that all markets prioritize interventions based on the same criteria—e.g., degree of need, likelihood of success, measurability of success in relevant metrics, programs already in place in the community, gaps in the community, resources available, as well as organizational strategy. Single-market providers have flexibility to use a less formal decision framework that determines improvement opportunities based on what's most important for the organization's strategy.

Regardless of the chosen approach, providers should use the following criteria to settle on final focus areas:

- Synergy with broader organizational goals, which sets up a business case that aligns to strategic priorities;
- Feasibility to inflect need over time, which ensures you can get a return on investment with the use of an evidence-based intervention;
- Ability to allocate internal resources, which guarantees that your organization can dedicate support to a targeted intervention; and,
- Resources for interventions already exist, which allows for economies of scale in resource-limited environments.

This section includes the following tools to help providers prioritize improvement opportunities and interventions:

- Quick reference to determine value-based impact of inflecting non-clinical needs
- Initiative scoring template
- Initiative decision guide

Source: Population Health Advisor interviews and analysis.

Opportunities Vary in Synergy Across Key Strategic Goals

When considering interventions, providers should first determine whether evidence supports it. All population health managers set priorities based on their ability to achieve the "quadruple aim" set by The Institute of Healthcare Improvement—better care, better health, better value, and better stakeholder satisfaction. However, research that addressing specific non-clinical needs achieves these goals is highly diffuse across the literature.

The table below summarizes the evidence base of common non-clinical care needs and maps them to subcomponents of the quadruple aim. Use this table to identify evidence-based non-clinical needs and brainstorm corresponding interventions that can help achieve your organization's population health goals. Refer to the Population Health Advisors ***Care Delivery Innovation Reference Guide*** to access the same prioritization matrix of clinical needs.

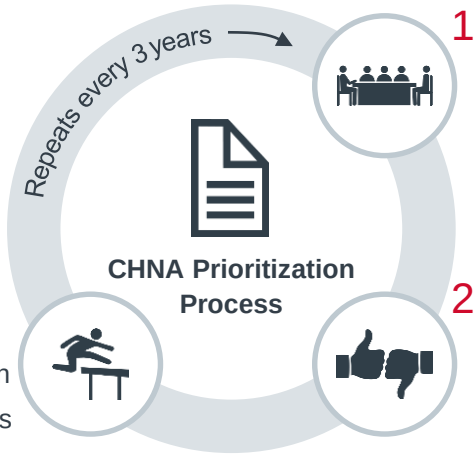
Non-clinical Need	Desired Provider Impact					Sample Interventions
	Reduces Cost	Rightsizes Utilization	Improves Health Outcomes	Improves Access	Improves Satisfaction	
Food insecurity	✔	✔	✔	✖	✖	• Refer to social services (e.g., Meals on Wheels) • Provide food vouchers or fresh produce
Housing instability	✔	✔	✔	✖	✔	• Refer to third-party services (e.g., extermination, legal services) • Partner to offer wraparound housing support
Lack of transit	✔	✖	✔	✖	✖	• Offer transportation vouchers or arrange rideshare services • Offer telehealth services
Lack of insurance	✔	✔	✔	✔	✖	• Help patients apply for entitlements (e.g., Medicaid) • Connect patients to pro bono health services • Enable self-care for manageable diagnoses
Community violence	✔	✔	✔	✖	✖	• Hold victim support groups • Sponsor anti-bullying education campaigns • Buy back guns
Health illiteracy	✔	✔	✔	✖	✖	• Incorporate teach-back into patient management • Design graphical instructions, written at third grade reading level
Language barriers	✔	✔	✔	✔	✔	• Offer translation and interpretation services • Allow patients to filter providers by spoken languages on website
Social isolation	✖	✔	✔	✖	✔	• Connect patients with community groups and peer support programs

Source: See page 38 in the appendix for detailed summary of sources; Population Health Advisor interviews and analysis.

Force Ranking Health Needs Removes Decision Ambiguity

When faced with a wide range of clinical and non-clinical challenges, providers can find it difficult to determine how to spend limited funds. At Adventist HealthCare, each hospital uses a scoring method to rank order which needs to address.

Standardized Tool, System Leadership Expertise Guides Prioritization Process



1 Senior hospital leadership councils convene to analyze each health need across nine factors

- Councils include hospital president, clinical and administrative leaders, VPs from corporate office
- Factors (listed below) are selected by Adventist HealthCare's Center for Health Equity and Wellness

2 Needs are force-ranked, with the highest-scoring needs declared as top priorities

- Each health need is given a score on a scale of one to five across individual factors, which are then totaled to indicate need and urgency to address
- Highest ranking needs are prioritized

3 Implementation process begins

- System leaders review and approve prioritization
- Population health leaders begin drafting implementation plan

Adventist HealthCare Example Prioritization Exercise Provides Score for Each Identified Need

Degree of Need/Urgency: 1= None 2= Low 3= Moderate 4= High 5= Extreme

	Factor	Reflection question	Health need score (out of possible 5)
Scope of Opportunity	Incidence and prevalence (1.5 weight)	Is it a major need throughout the community?	***5*** x (1.5)
	Presence and magnitude of disparities	Is it more pressing for some populations?	***3***
	Gaps and resources in the community	Is this need inadequately addressed by other organizations?	***2***
Synergy	Alignment with local health improvement priority areas (Yes= 1, No= 0)	Does it align with the county's priority areas?	***1***
Feasibility	Potential for measurable and achievable outcomes	Is it possible to make a measurable, positive impact?	***3***
	Change over time	Has it improved, declined, or remained stable?	***3***
Resource Availability	Existing programs, resources, and expertise (1.5 weight)	Does the health system have existing means to address the need?	***1*** x (1.5)
	Support from community	Has the community identified this need as a pressing concern?	***4***
	Existing community partnerships	Do partnerships exist that can be leveraged to address the need?	***3***
Total score (out of possible 46)			***28***

Source: "Community Health Needs Assessment," Adventist HealthCare, https://www.adventisthealthcare.com/about/community/health-needs-assessment/#Washington-Adventist-Hospital; Population Health Advisor interviews and analysis.

Adventist HealthCare's Health Needs Prioritization Tool

Use this tool to rank major community health needs identified by your needs assessment based on an overall needs/urgency score. Rate each factor on a scale of 1-5 to determine the total out of a possible 46 to order.

Score Degree of Need/Urgency
1= None 2= Low 3= Moderate 4= High 5= Extreme

Factor	List out each need to be rank ordered (e.g., food insecurity)			
	Identified Need	*Identified Need*	*Identified Need*	*Identified Need*
A. Incidence and prevalence (Weight: 1.5)				
B. Presence and magnitude of disparities				
C. Change over time				
D. Alignment with local health improvement priority areas (Yes = 1, No = 0)				
E. Potential for measurable and achievable outcomes				
F. Support from community				
G. Gaps and resources in the community				
H. Existing programs, resources, and expertise (Weight: 1.5)				
I. Existing community partnerships				
Score (1.5A + B + C + D + E + F + G + 1.5H + I)				

Source: Adventist HealthCare, Gaithersburg, MD; Population Health Advisor interviews and analysis.

Decision Tree Simplifies Understanding of Exclusion Criteria

Single-market providers have flexibility to use a less formal decision framework that determines improvement opportunities based on what's most important for the organization's strategy.

What Level of Investment and Involvement Is Needed to Address a Specific Community Health Need?

For each community health need that's negatively impacting your system, determine the best approach to address it effectively. Use the following questions to assess whether or not you should address the need independently, partner with community organizations, or deprioritize efforts in the space for now.

Community Health Need

Link Identified Health Need to Organizational Strategy

1	Does addressing this need align with my organization's strategic goals?	Yes	No
2	Will addressing this health need positively impact my organization's bottom line?	Yes	No
3	Would meaningful metrics be reasonably easy to measure?	Yes	No

If you responded "no" to any of these questions, consider deprioritizing efforts for now.
If you responded "yes" to these questions, continue to question 4.

Consider External Factors to Determine Feasibility

4	Is there an opportunity to inflect change by addressing this community need?	Yes	No
5	Is the community open to us addressing this need?	Yes	No
6	Is turnover of affected community members slow enough to inflect change?	Yes	No

If you responded "no" to any of these questions, consider deprioritizing efforts for now.
If you responded "yes" to these questions, continue to question 7.

Assess Internal Resource Availability to Address Need

7	If my organization already invests in addressing this need, are efforts working sustainably?	Yes	No
8	If we are not already investing, do we have the resources and expertise to lead the effort?	Yes	No

If you responded "no" to these questions, use questions 9-10 to determine if it's feasible to invest with partners.
If you responded "yes" to both questions, use questions 9-10 to determine if off-loading or partnering is an option.

Map Assets of Existing, Non-provider Community Efforts

9	Are other providers or organizations in my community already addressing this need?	Yes	No
10	Are there organizations that would be interested in supporting efforts to address this need?	Yes	No

If you responded "no" to either of these questions, consider deprioritizing efforts for now.
If you responded "yes" to both questions, go to the next page to identify how to address this need.

Source: Population Health Advisor interviews and analysis.

Step

3

Create Partnership Compacts

Choosing the Right Partners

Once your organization has decided on which need(s) to intervene on, you can begin to reach out to partners within the community who can strengthen your ability to deliver value to patients. By pooling resources across community partners, providers can address the upstream causes of poor health at scale and gain access to disengaged populations. The best partnerships are symbiotic, where partners share similar objectives and target populations. However, it's not enough to agree to the same overarching goals. Partnership success depends on outlining both the concrete metrics as well as a detailed plan identifying the staffing, time, and resource commitments. In creating community initiatives, providers need to do two things:

1. Select partners that offer the best cultural and strategic fit
2. Formalize expectations across each partners' role

When selecting the right partners, focus on those that can fill your organization's resource gaps, provide access to hard-to-reach patient groups, and are willing to measure the effectiveness of interventions.

This section includes the following tools to help providers create partnership compacts with external stakeholders:

- Community partner brainstorming guide
- Sample memorandum of understanding

Community Partner Checklist:

- ☐ Provides high quality services valuable to target population
- ☐ Conveniently located in community hotspots or have existing positive relationships with target population
- ☐ Maintains open, transparent communication channels
- ☐ Willing to meet expectations on workflow and information exchange
- ☐ Willing to meet standards set by risk-based arrangements

Hallmarks of Effective Relationships


Enthusiastic buy-in from leadership and frontline staff


Sustainable infrastructure for stakeholder engagement, feedback


Clear metrics for measuring ROI, transparency, accountability

Aligned back office capabilities for data transparency, continuity


Shared mission and culture

Source: Population Health Advisor interviews and analysis.

Brainstorm Potential Partners Based on Missing Assets

Partner selection starts with mapping needed assets to potential stakeholders. The guide below maps provider gaps in infrastructure, staffing, and patient reach across most community-based interventions to community organizations that can potentially fill those gaps.

Common Resource Gaps Mapped to Potential Partners

	Infrastructure	Staffing	Reach
Gaps	• Funding • Facility space and utilities • Data sharing and analytics	• Clinical and non-clinical expertise (e.g., social workers, behavioral health specialists) • Grant-writing assistance • Volunteers (e.g., peer coaches, medical students)	• Expanded clinical services (e.g., diagnostics, expanded hours) • Expanded social services (e.g., housing, food services) • Connection with at-risk populations
Potential Partners	• Local government • Social services (e.g., food banks, schools) • Behavioral health facilities • IT vendors • Medical schools	• Local pharmacy • Mental health or substance abuse providers • Academic institution • Community organizations (e.g., YMCA, Alcoholics Anonymous) • Social service providers (e.g., early childhood educators, occupational therapists)	• Housing and transportation services (e.g., homeless shelters, Uber) • Social service providers (e.g., Meals on Wheels, early childhood education centers) • Local clergy/chaplains • Legal services • Local businesses (e.g., supermarkets, barbershops)

Community Partner Brainstorming Guide

First re-create this brainstorming guide in an Excel file. Then, use it to chart the types of resources and roles needed to implement an initiative, as well as the types of organizations able to meet those gaps. Then, brainstorm potential partners.

Resource Gap	Type of Organization	Name of Organization	Main Point of Contact	Contact Information

Source: Population Health Advisor interviews and analysis.

Set Expectations with Detailed Goals and Responsibilities

Inter-organizational Contract Outlines Responsibilities of Providers, Clinic Staff

After selecting the right partners, providers need to create a mutually agreed upon framework for the partnership to ensure operational structures for decision making, roles, and each partner's responsibilities**.** LifeBridge Health, based in Baltimore, Maryland, relies on memorandums of understanding (MOUs) that align all partners within the Maryland Faith Health Network.

The Maryland Citizens' Health Initiative (MCHI) Fund, LifeBridge Health, and 68 local faith-based congregations founded this congregational health network in 2015. The congregational health network's goal is to manage transitions of care for high-risk patients by leveraging their faith-based community networks. Trained community liaisons offer social support and update hospital navigators with patients' health changes.

Congregations entering the network must sign the MOU and agree to stated responsibilities. Under the MOU, LifeBridge agrees to offer health education to community liaisons and provide culturally competent care to patients. Congregations agree to support the training of liaisons and maintain up-to-date information about participants. MCHI agrees to recruit congregations to the network and monitor its success. MOUs can be tailored to any new population health partnership.

Memorandum of Understanding Designates Party Responsibilities for Care Support

- Relationship between MCHI, the health system, and each congregation is grounded in a signed MOU
- All parties required to sign document before official admittance into network

Collaboration Between Hospital-Employed Navigator and Community Liaison Starts at Admission

Case in Brief: Maryland Faith Health Network at LifeBridge Health

- Three hospitals in Maryland's LifeBridge Health system (Sinai Hospital of Baltimore, Northwest Hospital and Carroll Hospital) that operate in urban, suburban and rural settings joined 68 faith-based congregations under the leadership of Maryland Citizens' Health Initiative Fund to form the Maryland Faith Health Network
- Hospital navigators initiate community post-discharge support upon patient admission and offer health education to faith-based liaisons; liaisons identify potential program participants and provide them with spiritual and social support post-discharge
- Network requires formal entry into the network by signing a memorandum of understanding among MCHI, the hospitals, and each congregation, outlining specific responsibilities
- To date, 121 liaisons serve more than 1,600 community members

Source: Population Health Advisor interviews and analysis.

Maryland Faith Community Health Network's MOU

MARYLAND FAITH COMMUNITY HEALTH NETWORK MEMORANDUM OF UNDERSTANDING

The Maryland Citizens' Health Initiative Education Fund, Inc., LifeBridge Health, Inc., and local faith communities have come together to create a Maryland Faith Community Health Network (the "Network") to address congregational and community health concerns and disparities. Each party is committed to full participation in the Network as stated in the following agreement:

Maryland Citizens' Health Initiative Education Fund, Inc. agrees to:

- Conduct outreach to local faith leaders, to engage their appointed representatives (Liaisons) fully in the design and implementation of the Network.
- Provide training to help build the capacity of new and active health ministries in congregations.
- Provide ongoing leadership to work with all partners to monitor, evaluate, improve and expand the Network.

LifeBridge Health, Inc. agrees to:

Extend partnering designated faith representative(s) (Liaisons) the following:

- Parking accommodations, as available.
- Health education programs as part of LifeBridge Health's existing population health initiative.

Share in the work of aligning the mutual strengths of congregation and health system, LifeBridge Health will:

- Respect the religious beliefs of all patients and provide high-quality, culturally competent care.
- Designate a Navigator to act as the point of contact for hospitalized congregants and Liaisons
- Provide meaningful reports on the impact of the program on local patient outcomes and successes.

Faith Leaders/Clergy Agree to:

- Support the partnership in prayer and worship to become God's instruments for health and wholeness in our community.
- Assign and oversee at least two Congregation Liaisons to complete necessary training and facilitate the program within the congregation.
- Maintain accurate and up-to-date contact information for congregational liaison with hospital systems.
- Extend an opportunity for members to be informed of the program and benefits and to become active participants.

Vincent DeMarco, Maryland Citizens' Health Initiative Education Fund: Vincent DeMarco

Neil Meltzer, LifeBridge Health: Neil Meltzer

Authorized Congregational Representative signature: _____

Partner Congregation:	
Congregational Contact Person: (print)	
Worship Address	
Mailing Address (if different)	
Phone	
Email	

Please mail, fax, or email completed form ATTN: Stephanie Klapper
Maryland Citizens' Health Initiative 2600 St. Paul St. Baltimore, MD 21218
Fax: 410-235-8963; Email: stephanie@healthcareforall.com
Please contact Stephanie with questions at 410-235-9000

Source: Maryland Citizens' Health Initiative, Population Health Advisor interviews and analysis.

Step

4

Evaluate Short- and Long-Term Performance

Evaluate Short- and Long-Term Performance

Providers should evaluate community health interventions over time to ensure optimal deployment of resources. You can track two types of metrics—process and outcomes.

Process metrics (e.g., patient participation in programs, screening rates) provide short-term feedback and often predict long-term outcomes. Outcomes measures (e.g., cost avoidance, mortality rates) focus on long-term indicators of quality and performance.

Population health leaders should work with your community partners to determine the right mix of both process and outcomes measures. Providers should make sure the measurement process and reporting burden is not overly taxing to community partners. Select short-term process measures that help you demonstrate rapid improvements to sustain leadership buy-in of promising initiatives before determining a more holistic ROI assessment. Agree on long-term outcomes measures with partners that provide more powerful data points that will meet the CFO's criteria for funding at-scale.

This section includes the following tools to help providers evaluate the short- and long-term performance of community-based initiatives:

- Metric evaluation guide
- Metric picklist for assessing community-based interventions

Tips for Inter-organizational Performance Evaluation

✓ Determine Evaluation Strategy

- Collaboratively stablish performance standards and evaluation processes
- Communicate goals across providers to ensure buy-in and alignment

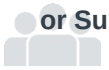
✓ Develop a Staff-Informed Data Collection Process

- Include metrics that are specific, but accessible across parties
- Focus on outcomes within staff control
- Prioritize realistically achievable targets

✓ Schedule Regular Evaluation Intervals

- Standardize auditing schedule (e.g., monthly, quarterly)
- Report outcomes regularly via ongoing cross-provider feedback mechanisms

✓ Collaboratively Analyze Data to Course Correct or Sunset Program



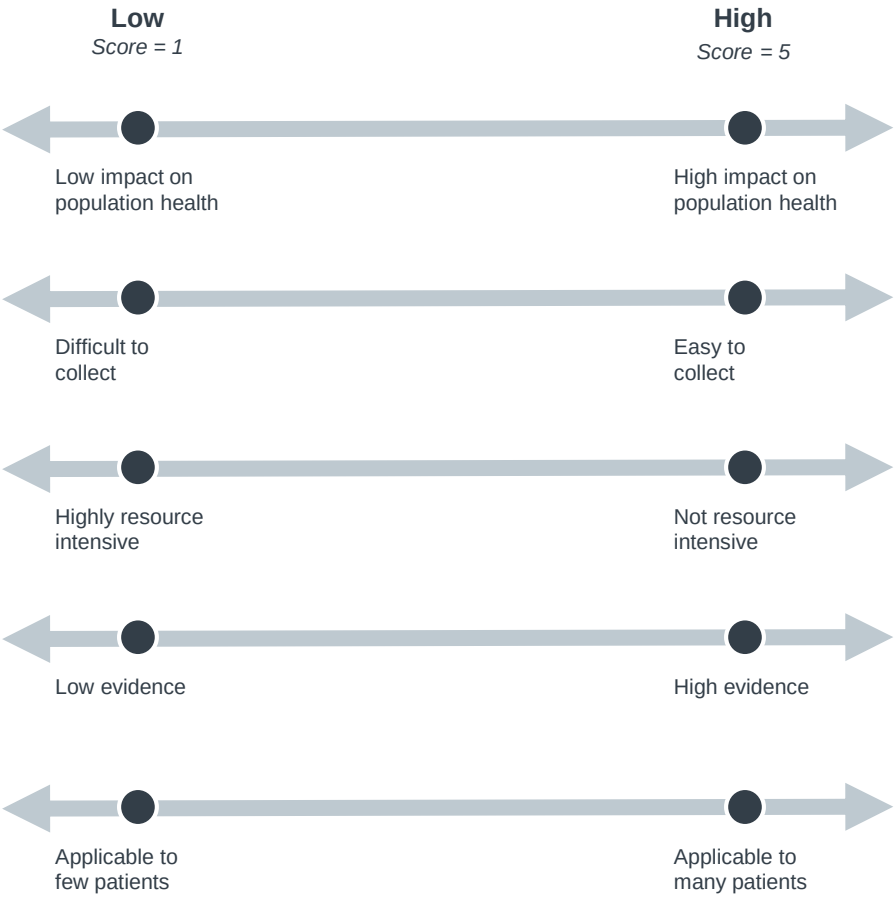
- Garner feedback on data from frontline staff to inform analysis
- Discuss outcomes across all stakeholders
- If necessary, collaboratively decide on course corrections

Source: Population Health Advisor interviews and analysis.

Then Evaluate Potential Metrics Against Five Criteria

When choosing metrics for your community health interventions, program leaders must select metrics that are meaningful but also are easy to collect. Program leaders can test potential metrics according to the framework below.

Effective Measures Score High on Five Vectors



Metric Evaluation Guide

Re-create this brainstorming guide in an Excel file, then list proposed metrics to include in your performance evaluation. Evaluate each metric on the five vectors and add up numbers to receive an overall score that can help with metric prioritization.

Metric	Meaningfulness	Ease of Collection	Resource Intensity	Scientific Support	Breadth	Overall Score

Source: Population Health Advisor interviews and analysis.

Focus Short-Term Proxy Metrics on Initiative Goals

While most programs strive for a financial ROI, positive returns may not be attainable until several years into a program. Instead, providers can create a scorecard or dashboard to track proxy metrics that directly link to long-term initiative goals, refreshing the dashboard quarterly. Process measures are a good substitute because they measure participation and reach of services. Without community and patient engagement in services, even the best initiatives will fail.

The table below highlights a range of common goals tied to accessible metrics. Programs should integrate any grant funder (or potential funder) requirements into the final dashboard to achieve proper alignment between the grant goals and partnership's focus areas.

Goals	Sample Metrics	
Service Volume and Reach	• New users and/or total users of service (e.g., community garden, supportive housing) • Scale of service (e.g., miles of walking path, number of affordable housing units, number of sites or counties served) • Frequency of service interaction (e.g., monthly encounters per patient)	• Duration of services (average) • Adherence to scheduled patient reassessments/outreach standards • Community referral completion rates • Staff or volunteer hours committed • Existence of partnership center or community advisory board
Health Access and Awareness	• Percentage of uninsured patients • Percentage of patients with regular PCP • Medical home enrollment rate • CAHPS composite: access to care • Average appointment wait time	• No-show appointments as a percentage of total scheduled appointments or sessions • Awareness of service availability (e.g., walking paths, health fairs) • Percentage of patients "very confident" in accessing or understanding health information
Preventive Care	• Percentage of patients not at risk out of those who complete a health assessment for alcohol consumption, exercise, stress management, nutrition, tobacco use	• Completion rates for specialty screenings (e.g., food insecurity, health literacy, depression) • Completion rates for preventive services (e.g., immunizations)
Patient Satisfaction and Health Status	• CAHPS composite: satisfaction with care	• Percentage of adults rating their health as "good" or better
Care Utilization	• Hospital admissions per 1,000 patients • Asthma- or other acute exacerbation-related hospitalizations • ED visits per 1,000 patients	• Per member per month cost of care • 30-, 60-, and 90-day readmissions rates for medical group patients admitted
Changes in Individual Behavior	• Increases in positive behaviors (e.g., physical activity, school attendance, consumption of fresh fruits and vegetables, savings rate)	• Decreases in negative behaviors or experiences (e.g., adverse childhood experiences, caregiver burden, substance misuse, school mobility of children, tobacco use)
Changes in Population Health/ Community Goals	• School readiness • Academic proficiency scores • Graduation rate • Prevalence of specific chronic diseases or conditions (e.g., obesity) • Unemployment rate • Poverty rate; percentage of children in poverty	• Homelessness rate • Crime rate (e.g., juvenile, violent, property) • Property values • Food desert-designated areas or grocery stores per ZIP code • Sense of community/social connectedness • Feeling of safety

Source: Population Health Advisor interviews and analysis.

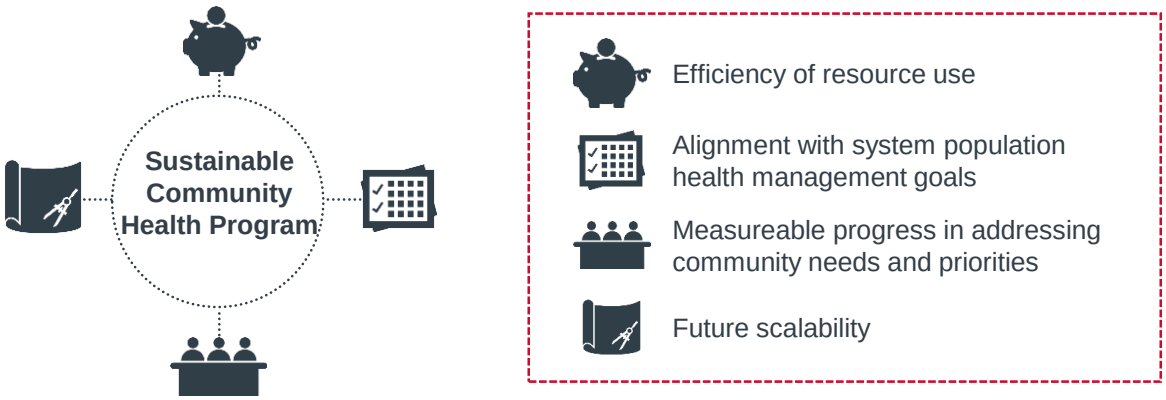
Sunset Programs if Ineffective

Community health intervention programs must continually prove value over time. Systems must remain impartial and practical about which programs they sustain, and redirect resources to other challenges when necessary.

Lehigh Valley Health Network (LVHN) recently restructured their Department of Community Health to focus on the development of sustainable front-line community health programs. Leadership was challenged to identify, catalogue, and align every community health program currently in progress and justify its continued operation.

This audit process now occurs annually, with each individual project held to four criteria: efficiency of resource use, alignment with system goals, progress in addressing community concerns, and potential for future scalability.

Annual Review Process Checks Programs Against Four Key Metrics



Case in Brief: Lehigh Valley Health Network

- Eight-campus health system based in Allentown and northeast PA
- Department of Community Health (DCH) maintains a diverse portfolio of outreach, education, and health improvement programs and uses collaborative cycles of improvement
- DCH leadership conducts annual sustainability review of every current project, determines which programs will be scaled up, continued, or discontinued

Source: "Preserving the Community Safety Net," Health Care Advisory Board, January 2018; Population Health Advisor interviews and analysis.

Appendix

Sources for Non-clinical Health Needs, Interventions Impact

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