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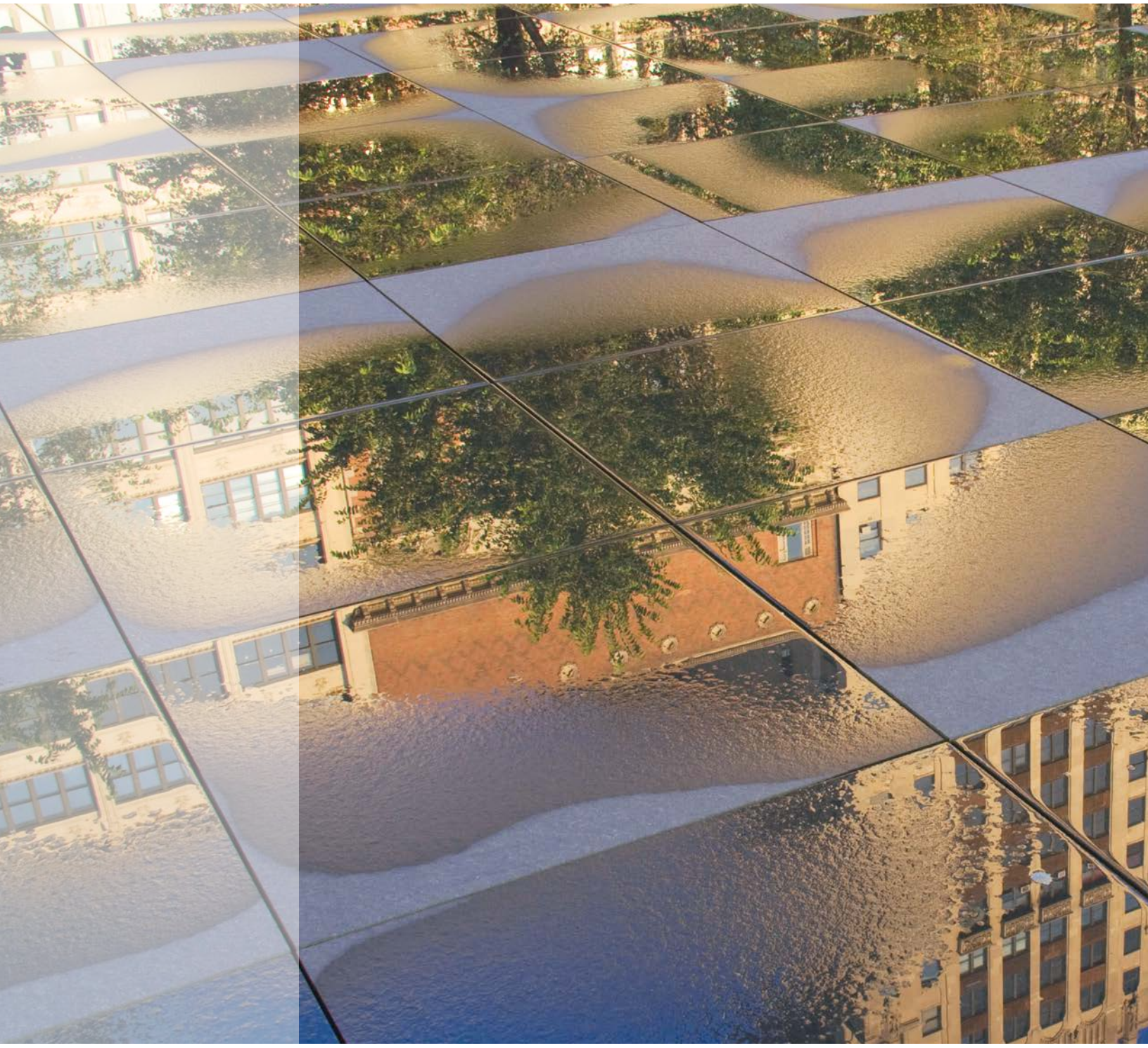
Swedish Covenant Hospital

Meeting a Diversity of Health Needs



Swedish Covenant Hospital's service area – with an estimated population of 630,000 – is home to many new immigrants and undocumented individuals.

Meeting a Diversity of Health Needs

With a service area consisting of one of the most diverse populations in the country, Swedish Covenant Hospital (SCH) faced obvious challenges with its community health needs assessment (CHNA). Located in Chicago, SCH serves residents in the north and northwest communities of the city and strives to stay true to its mission of "serving the physical, spiritual and psychological needs of our culturally diverse communities."

Accommodating the Diversity

Swedish Covenant Hospital's service area – with an estimated population of 630,000 – is home to many new immigrants and undocumented individuals. This results in the need for healthcare in dozens of languages, including Spanish, Polish, Korean, Russian and Arabic. "It can be very daunting for non-native English speakers to access health services, particularly if they have difficulty communicating with their healthcare provider," said Jenise Celestin, Community Relations Manager at Swedish Covenant Hospital.

Because of the diversity of the hospital's patients, more than 50 nationalities and languages are represented among the nurses, staff and physicians. "This helps bridge that language barrier to the community," said Celestin. "It's really important that we find a way to meet the needs of the community, and one of the most basic ways to do that is to make sure we are clearly communicating with one another."

When leaders at SCH decided to join the Metropolitan Chicago Healthcare Council (MCHC) collaboration for its CHNA, there were concerns about how to appropriately represent these culturally-diverse residents in the service area. "Because the phone surveys were only conducted in English and Spanish, we felt it was important to add on several other cultural-specific focus groups," said Celestin. "It was imperative to seek feedback from across our entire community, and the option to add these focus groups onto our community health needs assessment was very appealing."

The cultural-specific focus group participants included leaders from three of the most highly represented non-English speaking cultures in the area – Spanish, Polish and Asian Indian. "We felt that by tapping into the leaders from within those different cultural and ethnic groups, we were able to learn about their biggest barriers to accessing healthcare and their top health concerns."

Partnering and Change

Swedish Covenant Hospital's implementation strategy was approved by the hospital board in September 2013. Originally, there were 14 top needs identified through the PRC Community Health Needs Assessment. Members of the hospital's executive council and internal departments chose seven of those needs to include in the implementation strategy. "We chose the seven needs that our hospital was best equipped to address, and we were confident that other local organizations were working to address many of the other needs," said Celestin.

The number-one focus area for Swedish Covenant Hospital is access to healthcare services. "This is an overwhelming need in our community, particularly due to a high percentage of uninsured individuals, as well as the language barriers," said Celestin. "If we're not able to meet access needs, then we can't address a host of health issues, such as heart disease and stroke, obesity and maternal health concerns. We have to find a way to reach out to the community so they can access the care they need."

To address concerns about healthcare access, SCH created a partnership with Erie Family Health Center. In July 2013, Erie opened the Erie Foster Avenue Health Center on the hospital's campus. "There are a lot of uninsured individuals in our community, and we knew we wanted to help create medical homes for them," said Celestin. Erie Foster Avenue Health Center is a Federally Qualified Health Center (FQHC), which provides care to patients who come through the emergency department at SCH and might not have a medical home. "We're able to refer them here for their future primary care needs. This is one way we're working to improve

Collaborate

Swedish Covenant Hospital partnered with MCHC in 2009, and again in 2012, for its PRC Community Health Needs Assessment. Jenise Celestin, Community Relations Manager at the hospital, said SCH will more than likely participate in subsequent years. "It makes a lot of sense for us when you think about the staffing, time and cost. Plus, it's nice to partner with different organizations and be able to be part of the group that recognizes a problem and works to improve our community's health."

The **Metropolitan Chicago Healthcare Council** consists of more than 170 hospitals and healthcare organizations that work together to improve the delivery of healthcare services in the Chicago area.

Council Vision — High quality, accessible healthcare for all communities.

Council Mission — The MCHC is a membership and service organization dedicated to helping members care for their communities through access to healthcare and improved delivery of services.

Source: www.mchc.com

access to health services – by helping patients find a medical home where they can get care by a consistent provider."

In addition to working with internal departments and the hospital's executive council to see which needs the hospital was best able to meet, the hospital also formed an outside group – the Community Health Advisory Group. This group, consisting of about 40 members, is composed of leaders from the community, with representation from schools, senior centers, cultural organizations, business groups, elected officials, representatives from Federally Qualified Health Centers and other community leaders. Celestin said, "These are individuals who we know are very committed to the community and are stakeholders in the neighborhoods they serve."

One of the main areas of focus for the Community Health Advisory Group was the upcoming changes to the health insurance marketplace. "We sat down with this group in April 2013 and asked them what they had heard about the Affordable Care Act and the health insurance marketplace," said Celestin. "There was a consensus that no one knew much about it, even though the marketplace would be launching in less than six months and would affect thousands within our community."

Swedish Covenant Hospital took on a leadership role to educate the Group so that community leaders were aware of state and federal funding opportunities. Additionally, the meetings provided a forum to collaborate and form consortiums among smaller organizations to apply for joint funding. "We hosted phone calls and in-person meetings, and we emailed resources as information was made

available by the government. This way, the leaders could take the information back to their specific communities."

Community Funding

Current data from the CHNA has been used for five grant applications, totaling $400,000. Additionally, data from the assessment were shared with Lutheran Social Services, a partnering organization of Swedish Covenant Hospital, to support a grant request for $500,000 to expand mental health services in the community. "The data have definitely been used to support grant funding requests, and it will continue to be used for nearly all grants to justify identified needs within the community," Celestin said.

Swedish Covenant Hospital recently

Identifying Needs

Seven identified needs were addressed in Swedish Covenant Hospital's implementation strategy. Below are the top areas of need, as well as partnerships and resources developed to address them.

Swedish Covenant Hospital, Chicago, Illinois

1. **Access to Health Services** – Erie Family Health partnership; Health Insurance Marketplace education/assistance
2. **Heart Disease and Stroke** – Utilizing discharge navigators, "wellness coaches" and telemonitoring to follow up with and support patients at risk for readmission
3. **Nutrition, Physical Activity and Weight Challenges** – Provide year-long "Delicious Nutritious Adventures" healthy eating curriculum to students from Budlong Elementary School in partnership with Purple Asparagus; provide Women Out Walking 12-week walking program for women in English and Spanish (through IDPH grant)
4. **Mental Health and Mental Disorders** – Chief Nursing Officer to serve as commissioner for North River Expanded Mental Health Services Program Governing Commission
5. **Cancer** – Provide breast cancer screening, diagnosis and navigation to uninsured and underinsured women in the community through various grant awards
6. **Maternal, Infant and Child Health** – Pursue accreditation as a "Baby-Friendly Hospital"
7. **Respiratory Diseases** – Enhance pulmonary services through the addition of new technology and pursue certification as a Pulmonary Center of Excellence

Community Health Advisory Group

Partners

The **Community Health Advisory Group** was created to better address the identified needs in Swedish Covenant Hospital's service area. For example, feedback from the Group was used to educate residents about the health insurance marketplace.

Some organizations comprising the Community Health Advisory Group are:

- Albany Park Chamber of Commerce
- Asian American Institute
- Budlong Elementary School
- Cambodian Association
- EDA-WIC
- Centro Romero
- Chicago Public Schools
- Community Counseling Centers of Chicago (C4)
- Ecuador Unido
- Erie Family Health Center
- Hanul Family Alliance
- Heartland Health
- Indo-American Center
- Jane Addams Resource Corporation
- Korean American Community Services
- North River Commission
- Northeast (Levy) Senior Center
- Pan-African Association
- Polish American Chamber of Commerce
- Polish Initiative of Chicago
- World Relief Chicago

received a Women Out Walking grant from the Illinois Department of Public Health. This grant, which supports a 12-week walking challenge for women, addresses nutritional, physical activity and weight needs. "We plan to work closely with Erie Family Health Center and Heartland Health, two of the local FQHCs, to offer this program to women from our community in both English and Spanish," said Celestin.

The Swedish Covenant Hospital Foundation Board funded the 2012 PRC Community Health Needs Assessment. "We are grateful to the SCH Foundation and its Board. The community health needs assessment is going to have so many uses for their team and beyond, and I'm hoping we'll be able to partner with them when we do our next assessment," said Celestin.

Causing Internal Change

Being able to share data from department to department helps create buy-in across the organization. "It's good for these individual departments to see how things they're working on, or things they want to focus on, are grounded in data from the community."

Celestin serves on various committees within the hospital. She said it is helpful to be able to bring data from the community health needs assessment to these internal departments to reinforce the identified needs. "It's nice to be able to, for example, go to the OB staff and say, 'There is a need, we want to focus on it and we know you're interested in it as well.' This really helps to reinforce what we need to do that's right for the community."

In moving forward, Swedish Covenant Hospital will continue to find ways to support the needs of its diverse service area. Community health needs assessment data, along with community partnerships and collaborations, will fuel the hospital's path to improving the health of Chicago's north and northwest side communities.

Jana Distefano, MPH, Community Health Consultant & Analyst

Post CHNA Planning Interventions to Impact Population Health

Logic Models

In a previous *Community Health Connection* newsletter, I wrote about root cause analysis (RCA) as being a first step in program planning. Whether you utilize this approach or have an existing program in place, once your organization has decided on a path(s) for intervention, the next step is actual program development. Many different program planning tools exist, but one of the more common and popular is the logic model. Logic models provide a global perspective of the program and allow program planners to identify the level of change you expect to occur in population health.[1] Logic models can fill in gaps on implementation strategy documents and ensure that you use funding to its greatest potential. Producing a logic model also creates an opportunity to inform stakeholders about the program processes, gather input and ultimately foster collaboration.

Most logic models include a situation statement, inputs, outputs (what and who), outcomes [short (learning) and medium (action-behavior change)] and finally, the impact the program seeks to have in the community. Some also take into consideration assumptions and external factors.[2] Note that not all logic models will look alike, and it's important that program planners adapt the model to best fit their needs. Furthermore, in order to eliminate confusion, be sure the terminology is understood by all program planners involved before you begin.[3]

Phase 1:

Logic Model Development

In general, logic models should be created with a small group of people *(around five)* and involve several boxes and arrows that link together to demonstrate how the ideas connect to one another. Logic models do not need to have complete sentences, as they are just a roadmap for the program. And realize that, like successful organizations, these take time and energy to build. Many programs undergo multiple iterations before a final logic model is developed.[4] ***Figure A*** is a visualization of a basic logic model adapted from the W.K. Kellogg Foundation.[5]

Situation Statement

The first step in logic model development is to identify the health issue being addressed by the program and create a fitting situation statement. In our sample logic model, we'll create a roadmap to reduce childhood obesity.

In this example, the situation statement might read:

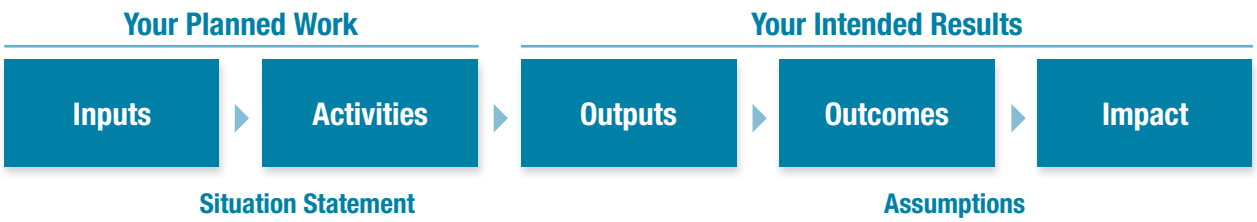
According to our PRC CHNA, 32% of children ages 5-17 are overweight or obese. Overweight and obese children are much more likely to become overweight adults and have an increased chance of chronic health conditions. Chronic health conditions negatively add to healthcare costs.

Assumptions

At this stage, you have most likely identified some root causes of the problem, or have found an evidence-based program that's already been proven to succeed in another community. *(For a list of sources for evidence-based programs, view our "Ideas for Action" document at www.PRConline.com/CHNA.)* Continuing to research and gain insight – from current literature, other community agencies and stakeholders – is beneficial to acquiring a complete understanding of not only the health issue at hand, but also the

A Basic Logic Model *W. K. Kellogg Foundation, 2004*

Figure A



external community and social factors that may influence the program.[6] On the logic model itself, you may want to include relevant findings within the "Assumptions" box. It is important not to overlook the examination of program assumptions because this process can help "identify flaws in the program design or implementation,"[7] and serve to check that planners have the necessary steps in place to ensure program success.

For example, assumptions for a program trying to decrease childhood obesity might include:

- *Nutrition education impacts obesity levels*
- *Residents want information about healthy eating*
- *YMCA staff will help with recruitment and advertising*

Impact

As with root cause analysis, when first developing the logic model it is sometimes easiest to begin at the end (i.e., with the long-term impact) and work backward. Impacts are the social, economic, political and/or environmental changes that you expect the program to have.[8]

Long-term impacts for the sample program might include:

- *Decrease risk factors for chronic disease, specifically:*
  - *Decrease in prevalence of diabetes*
  - *Decrease in prevalence of hypertension*
  - *Decrease in prevalence of high blood cholesterol*
- *Lower per capita spending on healthcare*

Outcomes

To identify the program's anticipated outcomes, consider what behavior or decision-making changes you expect the targeted community/audience to make after participation. Some logic models break these down into short-, medium- and long-term outcomes.

Here, you also might think of outcomes as the accountability steps that many hospitals are building into their implementation strategies following a community health needs assessment (CHNA). Additionally, consider which PRC Community Health Survey indicators might help you track the changes.

For our model, outcomes might include:

- *Parents and children increase knowledge about nutrition*
- *Parents regularly use knowledge and improve cooking skills to create healthy meals*
- *Parents seek out further information on nutrition from YMCA*
- *Increase daily fruit and vegetable consumption by 5% in 3 years*
- *Decrease sugary-drink consumption by 5% in 3 years*
- *Decrease obesity by 5% in 3 years*

Inputs

Now that you've identified the long-term impact and outcomes, you can go back to the beginning of the logic model and fill in the gaps. The first box on the logic model is "Inputs." In other words, what resources need to go into the program to make it successful? What will you need to get the program off the ground and continue to run smoothly?

Some inputs for our childhood obesity program model might include:

- *Nutritionists*
- *YMCA staff*
- *Volunteers*
- *Ingredients*
- *Physical space*
- *Funding*
- *Cooking materials*

Activities

"Activities" are what the program will actually do and who the activity will reach. These need to be specific, not only so that your evaluation process can determine that they occurred, but also to help you gain funding and buy-in from stakeholders.

For our example, activities might include:

- *Secure location for nutrition classes*
- *Create flyer promoting events*
- *Design cooking/nutrition education curriculum with hands-on demonstrations*
- *Create a pre-/post-test to measure knowledge changes*

Obesity Reduction Program Logic Model

Figure B

Inputs	Activities	Outputs	Outcomes	Impact
• Nutritionists • Cooking materials • Ingredients • Funding • Volunteers • Physical space • YMCA staff	• Secure location for nutrition classes • Create flyer promoting events • Design cooking/ nutrition education curriculum with hands-on demonstrations • Create a pre-/post-test to measure knowledge changes • Train volunteers to teach classes • Provide eight nutrition/cooking classes each month at local YMCA • Create an evaluation plan	• Target: 100 flyers passed out to current YMCA and community members • Target: 20 families attend 5+ monthly nutrition classes for 6 consecutive months • Target: Pre- and post-test score increase of +10%	• Parents and children increase knowledge about nutrition • Parents regularly use knowledge and improved cooking skills to create healthy meals • Parents seek out further information on nutrition from YMCA • Increase daily fruit and vegetable consumption by 5% in 3 years • Decrease sugary-drink consumption by 5% in 3 years • Decrease obesity by 5% in 3 years	• Decrease risk factors for chronic disease - Decrease prevalence of diabetes - Decrease prevalence of hypertension - Decrease prevalence of high blood cholesterol • Lower per capita spending on healthcare

Situation Statement

According to our PRC CHNA, 32% of children ages 5-17 are overweight or obese. Overweight and obese children are much more likely to become overweight adults and have an increased chance of chronic health conditions. Chronic health conditions negatively add to healthcare costs.

Assumptions

- Nutrition education impacts obesity levels
- Residents want information about healthy eating
- YMCA staff will help with recruitment and advertising

- *Train volunteers to teach classes*
- *Give eight nutrition/cooking classes a month at local YMCA*
- *Create an evaluation plan*

Outputs

Program planners next need to identify the "Outputs," or the targets, for the program. These might also be referred to as "units of service," "products" or "deliverables."[10] Outputs are the results you anticipate occurring during and immediately following program implementation. In addition, it's critical to have SMART outputs (Specific, Measurable, Attainable, Relevant and Time-Bound) so you already have measurement indicators identified for evaluation purposes.[12]

For the childhood obesity program model, outputs include:

- *Target: 100 flyers passed out to current YMCA and community members*
- *Target: 20 families attend 5+ nutrition classes for six consecutive months*
- *Target: Pre- and post-test score change of +10%*

Phase 2:

Reviewing/Finalizing the Logic Model

At this point, you have nearly completed your logic model; but before you consider it final, it's important to go back and double-check the "logic." You can do this by using "if-then" statements; for example, the sample logic model may read *(**Figure B**)*: [13,14]

*"**IF** we have nutritionists, cooking materials and a physical space, **THEN** we can design nutrition education curriculum.*

➥ ***IF** we have a nutrition education curriculum, **THEN** we can share it with 20 families.*

➥ ***IF** we have families attend, **THEN** we can increase*

Evaluation of Indicators *W. K. Kellogg Foundation, 2004*

Figure C

Focus Area	How to Evaluate	Indicators
Influential Factors (Assumptions)	Compare the nature and extent of influences before (baseline) and after the program.	Measures of influential factors – may require general population surveys and/or comparison with national data sets.
Resources	Compare actual resources acquired against anticipated.	Logs or reports of financial/staffing status.
Activities	Compare actual activities provided, types of participants reached against what was proposed.	• Descriptions of planned activities. • Logs or reports of actual activities. • Descriptions of participants.
Outputs	Compare the quality and quantity of actual delivery against expected.	• Logs or reports of actual activities. • Actual products delivered.
Outcomes & Impacts	Compare the measures before and after the program.	Participant attitudes, knowledge, skills, intentions and/or behaviors thought to result from your activities.

knowledge about nutrition.

➥ ***IF** we increase knowledge about nutrition, **THEN** we can decrease risk factors for chronic disease."*

If the logic flows and the objectives are clearly defined, and if stakeholders are comfortable that the logic model addresses the necessary steps/activities/resources to achieve the desired outcomes,[15] your model is complete. The model does not need to be static and can evolve and grow alongside the program. It's also important to note that it might be worthwhile to share the model with potential partners to obtain buy-in and promote collaboration.

In the end, logic models can help track, monitor and identify limitations, and determine progress in health programs – whether it is for a program you design from scratch, one that you model off an evidence-based practice or one that already exists in the community – or to fulfill a requirement for programs submitted as part of a grant request.

Phase 3:

Establishing Indicators for Evaluation

Logic models can also serve as the foundation for your evaluation tools. Remember that your PRC Community Health Survey can help fill in evaluation data gaps, and can be used as the mechanism to track/obtain/record some of the more difficult-to-obtain data indicators. ***Figure C*** is a visualization of a starting point for establishing your evaluation plans.[16]

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Case File **Medical Center of Central Georgia**
Macon, Georgia

Healthy in the Heart of Georgia

Located near the geographic center of the state, Macon is the county seat of Bibb County, and the fourth largest city in Georgia. Home to The Medical Center of Central Georgia (MCCG), Bibb County was one of seven counties selected for MCCG's 2012 PRC Community Health Needs Assessment (CHNA), and the most populous of the seven-county area.

With an estimated population of just over 400,000, the selected seven-county area was based on geography as well as patterns of utilization for the services of Central Georgia Health System (CGHS), which includes MCCG. The six counties contiguous to Bibb that were also included in the assessment are Crawford, Houston (home to Robins Air Force Base), Jones, Monroe, Peach and Twiggs. Peach County is home to another hospital under CGHS – The Medical Center of Peach County.

Aside from federal regulations requiring non-profit hospitals to complete a CHNA, Charles Krauss, Health Educator with The Medical Center of Central Georgia, said it's important to know all of the health needs of the community. "Each of the counties that borders Bibb County may have particular needs that are different than other counties in the area," said Krauss.

Rosalind McMillan, Assistant VP of Population Health, added, "The voice of each of these communities, our respective constituencies, must be heard to understand what their needs are."

The CHNA was completed with survey responses from 1,000 residents and five focus groups consisting of 34 key informants from the seven-county area.

"We developed our implementation plan in response to the CHNA, which we used as a primary source of data," said McMillan. "We made sure that we were responding to the needs that were identified through the assessment, and the data were very useful in terms of scoping and prioritizing what we would focus on based on potential impact."

Krauss added, "The findings were used to prioritize the health issues identified in the CHNA that would be initially targeted to address, namely: access to health services; diabetes prevention; nutrition, physical activity and weight status; childhood obesity; COPD and tobacco use; and injury and violence prevention."

Community Partners Are Key

McMillan said that the areas of opportunity identified through the CHNA and prioritized for implementation shared a key criterion – collaboration. There were opportunities to work with community resources already addressing the identified issues or that were very interested in partnering with CGHS to enhance community capability to respond to the identified needs. These community resources include a Federally Qualified Health Center, a free health clinic, primary care physicians, The Wellness Center, pediatric specialists, Diabetes Healthways and other community agencies.

"These partnerships are key to improving the health of the community," said McMillan. "The results of the CHNA were shared with our partners and input was obtained from them in regard to the implementation strategy and who all needed to be involved."

Three of the target areas prioritized for implementation are described.

> **"The data were very useful in terms of scoping and prioritizing what we would focus on based on potential impact."**

Access to Health Services | Forty percent of residents in the survey area reported some type of difficulty or delay in obtaining healthcare services. Nineteen percent of residents reported having no health insurance. In an attempt to increase access to health services needed by residents, the hospital is working with the Macon Volunteer Clinic (a free health clinic serving employed but uninsured residents of Bibb County), First Choice Primary Care (a Federally Qualified Health Center), Community Health Works (a multi-sector, non-profit organization in central Georgia committed to improving the health of residents and bolstering the capacity of the local healthcare community to serve the needs of central Georgia's uninsured and medically underserved residents) and several other community agencies.

Collaboratively, these agencies work as partners to increase access, remove barriers, reduce disparities and ensure a better quality of life for those who live in the area communities. Of the residents surveyed, 9.7% indicated that lack of transportation was a barrier to accessing medical care. To alleviate this, transportation will be provided at no cost to participants for some of the programs and services implemented. Additionally, there is no cost to participants for required supplies or to participate in classes.

Diabetes | In the total survey area, 15.6% of residents reported having been diagnosed with diabetes, with a higher prevalence in Bibb County (17%). To address the need for diabetes education and prevention, MCCG has partnered with the Macon Volunteer Clinic, First Choice Primary Care, primary care physicians in Peach County (diabetes prevalence in Peach County was 17.3%), CGHS's Wellness Services, Home Health and Diabetes Healthways.

Dr. Lynn Denny, Medical Director for The Macon Volunteer Clinic, said,

"I am thrilled that the people I serve at Macon Volunteer Clinic will have access to diabetes education onsite and will be able to learn about diet and exercise and what they can do to avoid getting diabetes or to better manage their diabetes if they already have it."

Krauss added, "Patients who make minimum wage may not have the time to take off work, and they may not have the money to pay for the class. Therefore, we will send diabetes and wellness educators to various sites to provide these services at times that are convenient for them."

Nutrition, Physical Activity and Weight Status | By partnering with the local parks and recreation department, MCCG was able to focus on nutrition, physical activity and weight status. To grow the 36.4% of total area adults participating in regular, sustained moderate or vigorous physical activity, MCCG is helping to rebuild one of the oldest parks in Macon. "The parks and recreation department is putting in a walking and bicycle track, and we'll be donating the money to purchase a permanent water station," said Krauss.

Within the study area, 26.4% of children ages 5 to 17 are overweight or obese, and 18.4% are classified as obese. To encourage physical activity for children in the area, The Wellness Center in Macon hosts a program called Camp Fun 'N Fit. The day camp is designed to get children up and moving and excited about physical activity. Due to the intensity, the camp is limited to 30 children per camp. The camp – scheduled each June – hosts classes ranging from nutrition education and group exercise, to field trips and swimming. The nutrition education and cooking classes will also be a family affair. MCCG has agreed to pay the enrollment fees for any obese child or child diagnosed with diabetes who enrolls. There will also be a maintenance support program offered by physicians to children who participate in the camp.

MCCG is also partnering with pediatric endocrinologists to increase awareness throughout the central Georgia region about childhood obesity and risk factors associated with being overweight or obese.

Sticking to the Mission

Although implementing new initiatives that warrant change in a community can be a daunting task, MCCG is confident, knowing it is not alone in this process and that there are many other community partners interested in and committed to improving residents' health status and elevating overall quality of life.

"One of the things I'm very appreciative of is that we work very closely with community agencies already involved and interested in improving the health of the community," said Krauss. "Their interest aligns very well with MCCG's mission, which is to enhance the health status of our community in partnership with our medical staff, our employees and community organizations."

Terms You Need to Know

Whether you are new to the community health world or a veteran, PRC has compiled this short glossary of terms to help us all speak the same language as we work toward a common goal. An extended glossary of terms can be found at www.PRConline.com/CHNA.

1 Age-Adjusted Rate

A rate that has been statistically modified to eliminate the effect of different age distributions among different populations.[1]

2 Assessment

Assessment is defined as:

A. Collecting, analyzing and using data to educate and mobilize communities, develop priorities, garner resources and plan actions to improve public health.

B. One of the three core functions of public health is involving the systematic collection and analysis of data in order to provide a basis for decision-making. This may include collecting statistics on community health status, health needs, community assets and/or other public health issues. The process of regularly and systematically collecting, assembling, analyzing and making available information on the health needs of the community, including statistics on health status, community health needs and epidemiologic and other studies of health problems.[9]

3 At-Risk Populations

Certain factors will increase a person's risk of negative outcomes on health, safety and well-being; they may experience significant barriers and therefore need help maintaining medical care, food and shelter. Factors that increase the risk of harm, for example, during an influenza pandemic include:

- Economic disadvantage (e.g., having too little money to stockpile supplies, or to stay home from work for even a short time);
- Absence of a support network (e.g., some children; homeless; travelers; and the socially, culturally or geographically isolated);
- Requiring additional support to be independent in daily activities because of a physical, mental or developmental disability; substance abuse or dependence; vision or hearing impairment; or certain other medical or physical conditions;
- Difficulty reading, speaking or understanding English.

These factors are typical of at-risk population characteristics.[9]

Behavioral Risk Factor

Any particular behavior or behavior pattern which strongly yet adversely affects health. It increases the chances of developing a disease, disability or syndrome. Examples of these factors include tobacco use, alcohol consumption, smoking, obesity, physical activity and sexual activity.[8] Sometimes referred to as modifiable risk factors (meaning you can take measures to change them), as opposed to non-modifiable risk factors (such as age, gender, family history), which cannot be changed.[10]

5 Chronic Disease

Chronic diseases are diseases of long duration and generally slow progression. Chronic diseases, such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes, are by far the leading cause of mortality in the world.[11] A chronic disease has one or more of the following characteristics: it is permanent; leaves residual disability; is caused by a nonreversible pathological alteration; requires special training of the patient for rehabilitation; or may be expected to require a long period of supervision, observation or care.[5]

6 Collective Impact

The commitment of a group of actors from different sectors to a common agenda for solving a complex social problem. In order to create lasting solutions to social problems on a large-scale, organizations — including those in government, civil society and the business sector — need to coordinate their efforts and work together around a clearly defined goal. Collective impact is a significant shift from the social sector's current paradigm of "isolated impact," because the underlying premise of collective impact is that no single organization can create large-scale, lasting social change alone. There is no "silver bullet" solution to systemic social problems, and these problems cannot be solved by simply scaling or replicating one organization or program. Strong organizations are necessary but not sufficient for large-scale social change. Not all social problems are suited for collective impact solutions. Collective impact is best employed for problems that are complex and systemic rather than technical in nature.[4]

7 Cultural Competence

A set of skills that result in an individual understanding and appreciating cultural differences and similarities within, among and between groups and individuals. This competence requires that the individual draws on the community-based values, traditions and customs to work with knowledgeable persons of and from the community developing targeted interventions and communications.[2]

8 Epidemiology

The study of the distribution and determinants of health and disease in populations.[9]

9 Evidence-Based Practice

Evidenced-based practice involves making decisions on the basis of the best available scientific evidence, using data and information systems systematically, applying program-planning frameworks, engaging the community in decision-making, conducting sound evaluation and disseminating what is learned.[9]

10 Health Disparities

Health disparities refer to differences in population health status that are avoidable and can be changed. These differences can result from environmental, social and/or economic conditions, as well as public policy. These and other factors adversely affect population health.[9]

11 HealthForecast.net®

An interactive online tool for PRC community health clients designed to make PRC Community Health Needs Assessment data widely available to the communities they reflect. HealthForecast.net® was designed to help hospitals, health systems, health departments, foundations, civic organizations and consumers promote community health and wellness by connecting people to information, ideas and resources. It is also a solution for nonprofit hospitals to fulfill public dissemination requirements.[7]

12 Incidence

Rate of occurrence of new cases of a specified condition in a specified population within some time interval, usually a year.[2]

13 Morbidity

Illness or lack of health caused by disease, disability or injury.[2]

14 Mortality

A measure of the incidence of deaths in a population.[2]

Population Health

A cohesive, integrated and comprehensive approach to health considering the distribution of health outcomes within a population, the health determinants that influence the distribution of care and the policies and interventions that impact and are impacted by the determinants.[9]

16 Prevalence

The number of cases of a disease, infected people or people with some other attribute present during a particular interval of time. It often is expressed as a rate.[5]

17 Prevention

Primary prevention consists of strategies that seek to prevent the occurrence of disease or injury, generally through reducing exposure or risk factor levels. These strategies can reduce or eliminate causative risk factors (risk reduction). Secondary prevention consists of strategies that seek to identify and control disease processes in their early stages before signs and symptoms develop (screening and treatment). Tertiary prevention consists of strategies that prevent disability by restoring individuals to their optimal level of functioning after a disease or injury is established.[9]

18 Primary Data

Information collected by the researcher directly through instruments such as surveys, interviews, focus groups or observation. Tailored to one's specific needs, primary research provides the researcher with the most accurate and up-to-date data.[6]

19 Secondary Data

Secondary data are those data which have been collected in the past, collected by other parties or result from combining data or information from existing sources.[9] Researchers reuse and repurpose information as secondary data because it is easier and less expensive to collect. However, it is seldom as useful and accurate as primary data.[6]

Social Capital

A composite measure that reflects both the breadth and depth of civic community (staying informed about community life and participating in its associations) as well as the public's participation in political life. It is characterized by a sense of social trust and mutual interconnectedness, which is enhanced over time through positive interaction and collaboration in shared interests.[2]

21 Social Determinants of Health

The complex, integrated and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services and structural and societal factors. Social determinants of health are shaped by the distribution of money, power and resources throughout local communities, nations and the world.[3]

22 Surveillance

The ongoing systematic collection, analysis and interpretation of data (e.g., regarding agent/hazard, risk factor, exposure, health event) essential to the planning, implementation and evaluation of public health practice, closely tied with the timely dissemination of these data to those responsible for prevention and control.[2]

23 Underserved Populations

Populations with barriers to the healthcare system include the uninsured, the underinsured and socially disadvantaged people. Socially disadvantaged people include all people who, for reasons of age, lack of education, poverty, culture, race, language, religion, national origin, physical disability or mental disability, may encounter barriers to entry into a coordinated system of public health services and clinical care.[2]

24 Vital Statistics

Data derived from certificates and reports of birth, death, fetal death, induced termination of pregnancy, marriage (including divorce, dissolution of marriage or annulment) and related reports.[2]

25 Vulnerable Populations

A group of people with certain characteristics that cause them to be at greater risk of having poor health outcomes. These characteristics include, but are not limited to, age, culture, disability, education, ethnicity, health insurance, housing status, income, mental health and race.[2]

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An extended glossary of terms can be found at www.PRConline.com/CHNA.

Collective impact is a new way of thinking about transforming communities. The following, originally published January 26, 2012, in *Stanford Social Innovation Review*, is the beginning of an informative article discussing what it takes for collective impact to succeed and where to begin the journey. View this entire article at http://bit.ly/stanfordsocial.

Collective Impact

Channeling Change: Making Collective Impact Work

What does a global effort to reduce malnutrition have in common with a program to reduce teenage substance abuse in a small rural Massachusetts county? Both have achieved significant progress toward their goals: the Global Alliance for Improved Nutrition (GAIN) has helped reduce nutritional deficiencies among 530 million poor people across the globe, while the Communities That Care Coalition of Franklin County and the North Quabbin (Communities That Care) has made equally impressive progress toward its much more local goals, reducing teenage binge drinking by 31 percent. Surprisingly, neither organization owes its impact to a new previously untested intervention, nor to scaling up a high-performing nonprofit organization. Despite their dramatic differences in focus and scope, both succeeded by using a collective impact approach.

In the winter 2011 issue of *Stanford Social Innovation Review* we introduced the concept of "collective impact" by describing several examples of highly structured collaborative efforts that had achieved substantial impact on a large scale social problem, such as The Strive Partnership educational initiative in Cincinnati, the environmental cleanup of the Elizabeth River in Virginia, and the Shape Up Somerville campaign against childhood obesity in Somerville, Mass. All of these initiatives share the five key conditions that distinguish collective impact from other types of collaboration: a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and the presence of a backbone organization.

We hypothesized that these five conditions offered a more powerful and realistic paradigm for social progress than the prevailing model of isolated impact in which countless nonprofit, business, and government organizations each work to address social problems independently. The complex nature of most social problems belies the idea that any single program or organization, however well managed and funded, can singlehandedly create lasting large-scale change.

Response to that article was overwhelming. Hundreds of organizations and individuals from every continent in the world, even including the White House, have reached out to describe their efforts to use collective impact and to ask for more guidance on how to implement these principles.

Even more surprising than the level of interest is the number of collective impact efforts we have seen that report substantial progress in addressing their chosen issues. In addition to GAIN and Communities That Care, Opportunity Chicago placed 6,000 public housing residents in new jobs, surpassing its goal by 20 percent; Memphis Fast Forward reduced violent crime and created more than 14,000 new jobs in Memphis, Tenn.; the Calgary Homeless Foundation housed more than 3,300 men, women, and children and contributed to stopping what had been the fastest growing rate of homelessness in Canada; and Vibrant Communities significantly reduced poverty levels in several Canadian cities.

The initiatives we cited in our initial article have also gained tremendous

More and more people, however, have come to believe that collective impact is not just a fancy name for collaboration, but represents a fundamentally different, more disciplined, and higher performing approach to achieving large-scale social impact.

traction: Shape Up Somerville's approach has now been adapted in 14 communities through subsequent research projects and influenced a national cross-sector collaborative. The Strive Partnership recently released its fourth annual report card, showing that 81 percent of its 34 measures of student achievement are trending in the right direction versus 74 percent last year and 68 percent two years ago. Its planned expansion to five cities when the article came out has since been vastly expanded as more than 80 communities (including as far away as the Ruhr Valley in Germany) have expressed interest in building on The Strive Partnership's success.

Part of this momentum is no doubt due to the economic recession and the shortage of government funding that has forced the social sector to find new ways to do more with less—pressures that show no signs of abating. The appeal of collective impact may also be due to a broad disillusionment in the ability of governments around the world to solve society's problems, causing people to look more closely at alternative models of change.

More and more people, however, have come to believe that collective impact is not just a fancy name for collaboration, but represents a fundamentally different, more disciplined, and higher performing approach to achieving large-scale social impact. Even the attempt to use these ideas seems to stimulate renewed energy and optimism. FSG has been asked to help launch more than one dozen collective impact initiatives, and other organizations focused on social sector capacity building such as the Bridgespan Group, Monitor Institute, and the Tamarack Institute in Canada, have also developed tools to implement collective impact initiatives in diverse settings.

As examples of collective impact have continued to surface, it has become apparent that this approach can be applied against a wide range of issues at local, national, and even global levels. In fact, we believe that there is no other way society will achieve large-scale progress against the urgent and complex problems of our time, unless a collective impact approach becomes the accepted way of doing business.

At the same time, our continued research has provided a clearer sense of what it takes for collective impact to succeed. The purpose of this article, therefore, is to expand the understanding of collective impact and provide greater guidance for those who seek to initiate and lead collective impact initiatives around the world. In particular, we will focus on answering the questions we hear most often: How do we begin? How do we create alignment? And, How do we sustain the initiative?

To view the rest of this article, visit http://bit.ly/stanfordsocial.

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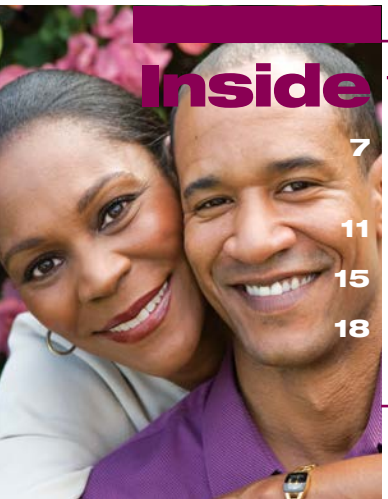

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