Using Data: From Planning to Evaluation

Wednesday, March 14, 3:30 PM

Telling Community Impact Stories Through Data Visualization
Meredith Root-Bowman, Community Health Epidemiologist, Presbyterian Healthcare Services
Brian Barnes, Project Manager, Resilient Solutions 21 (RS21)
Roberta Rael, Executive Director and Founder, Generation Justice

In an effort to evaluate progress, detect areas for improvement, and tell our community health story, The Presbyterian Center for Community Health investigated a large number of local and national options for the creation of a community health dashboard and other fee and free technologies for assessment, evaluation, and storytelling. In our efforts to tell the story of how we are working collaboratively across sectors to create a culture of health, we created meaningful community collaborations around data to better display and contextualize data.

The host of widely available resources will be presented as well rationale behind why the Presbyterian Center for Community Health chose to focus on an innovative and customized digital data visualization project and a video storytelling and youth empowerment project that captures the unique culture of our communities. We will also demonstrate and discuss our applications of tools like free ArcOnline mapping products and subscription services like LiveStories into our cross-sector coalition work to bridge aims, empower partners with accessible data, and demonstrate impacts of collective impact efforts to improve population health.

The presentation will include an interactive demonstration, opportunity for Q&A, feedback, and discussion around the process of creation and use of these visualization products and methods. Participants will learn how, through the act of storytelling, we have been able to forge new and stronger partnerships, attract new sectors to the table, and bridge bright spots in the community where there are ongoing efforts to tackle complex community-wide concerns.

Learning Objectives:
• Identify and locate available resources and options for community health data visualization
• Apply methods for collaboration around data visualization and storytelling to their own community stories and cross-sector coalitions
• Evaluate products and methods for fit taking into account cultural, budgetary, and technical requirements

Wednesday, March 14, 5:00 PM

Bridging Health and Community Development through Evaluation
Jessica Mulcahy, Director, Success Measures Philanthropic Evaluation Strategies, NeighborWorks America
Susan Eby, Vice President of Clinical Services, Community Partners
Carrie Copeland, Program Director, Cornerstone Community Housing
As more community development organizations partner with healthcare institutions to bridge the delivery of housing, food security, safety and other programs that address the underlying determinants of health, finding rigorous, yet feasible, ways to measure the health outcomes of these efforts is critical.

Learn how a partnership between two national housing and community development intermediaries, Enterprise Community Partners and Success Measures at NeighborWorks America, is building the capacity of community-based organizations to track health outcomes of a range of housing and community-based programs. This national evaluation initiative, the Health Outcomes Demonstration Project, is supported by the Robert Wood Johnson, Kresge and Hearst Foundations.

In this moderated panel, session attendees will hear from two participant organizations as they reflect on the bridge that they are building between community development and health outcomes. Cornerstone Community Housing from Eugene, OR will discuss how it is evaluating its Healthy Homes program, which uses the platform of affordable housing to provide supportive services focused on health and wellness. Cornerstone’s evaluation focuses on outcomes related to nutrition, wellness, physical and mental health, physical activity, access to health care, and social cohesion. Community Partners from Riviera Beach, FL will discuss how it is evaluating its High Fidelity Wraparound program, an evidence-based, intensive planning and service coordination process that builds bridges to needed medical and behavioral health services for clients to enhance outcomes. The evaluation focuses on the short-term outcomes of increased participation in activities related to physical and mental health and longer-term outcomes such as family stability and improved well-being. Based on their completed evaluation designs and one round of baseline data, the panelists will discuss the benefits and challenges of integrating health outcome measurement into community development programming, the evaluation approaches used and how they are using the data.

This session will be moderated by Lindsay Duerr, Program Director, Impact Assessment & Evaluation at Enterprise Community Partners, Inc.

Learning Objectives:
• Understand how what it takes operationally for housing and community development partners to carry out thoughtful, rigorous evaluation of health outcomes
• Learn about how you and your community partners can use the Success Measures Health Outcome Tools, available in a free online publication, to measure a range of community-based programming
• Explore how institutional partners can invest in evaluation capacity building for their community partners and the technical and other support needed to do so

Thursday, March 15, 11:30 AM

Identifying Need at the ZIP Code Level

Brian Waterman, Vice President, Analytic Business Solutions, Missouri Hospital Association
Peter Rao, Vice President of Quality Evaluation and Program Development, Missouri Hospital Association

The places where we live, work, learn and play are bridges to our health. Having granular information on health factors and health outcomes in the places where patients live can help hospitals and communities take action to help create and sustain a healthy population. Community health needs assessments (CHNAs) have provided a robust platform to focus on population health across sectors.

Population health improvement requires communitywide partnerships to address the social, economic, environmental, clinical and behavioral factors that affect health and lead to poor health outcomes. The concept of an individual’s ZIP code being a more powerful predictor of health than their genetic code is gaining widespread acceptance in the medical community. Population health improvement strategies are enhanced by precision analytics designed to target scarce community health improvement resources. Sub-county health data enables the use of resources in a focused
approach and provides for upstream preventive approaches to addressing health factors that predict future health outcomes of populations. Obtaining a baseline on the trajectory towards higher quality and lower costs requires a robust population health assessment tool and maturity scale. Together these will assist hospitals with targeted educational intervention and guidance.

In this session, presenters will review a recent study between the Hospital Industry Data Institute and Washington University School of Medicine. Supported by The Robert Wood Johnson Foundation through a 2015 County Health Rankings Research Award, the Missouri Health Rankings Project extends the CHR population health model to the ZIP code level using widely available discharge data. The session will also cover a collaboration between MHA and the Health Research & Educational Trust to extend the ZIP Health Rankings to other states. Finally, the presenters will provide case studies on the use of these data to inform CHNAs and evaluation of population health maturity among Missouri hospitals.

Learning Objectives:
• Develop a population health framework
• Practical implications of utilizing ZIP code data towards population health improvement
• Align ZIP code level data to advance population health

Thursday, March 15, 2:15 PM
Serving Complex Care Populations with Supportive Housing Using Data Driven Strategies
Marcella Maguire, Director of Health Systems Integration, CSH The Source for Housing Solutions
Sarah Gallagher, Director of Strategic Initiatives, CSH The Source for Housing Solutions

The presentation will share the results from a 5-year, 4-site randomized control trial study. The study matched data between state and communities’ health care sectors and homelessness response systems to determine what individuals were high need users of both systems. Data-driven targeting strategies were used to determine the sample population of individuals with both complex care needs, high-cost health care histories, and chronic homelessness. Individuals either were randomized to the usual system experience or expedited access to supportive housing.

As data system access allowed, tenants were followed for at least one year to determine housing stability and health care outcomes. Cost data as well as health and wellness data were collected to determine impact of the project. Results indicate that it is possible to develop and deliver supportive housing for homeless individuals who are high utilizers of health care. Supportive housing can reduce utilization of shelters and costly health care, primarily through reduced hospitalizations, and especially for those who were most costly at baseline. These reductions can substantially offset program costs. However, participants may still experience deep and complex health problems while in the program.

Learning Objectives:
• Develop successful strategies to data match between health care and homelessness systems
• Evaluate strategies for bringing together cross sector community partners to address the needs of a complex care population
• Understand results from a 5-year randomized control trial using Supportive Housing as an intervention

Thursday, March 15, 4:00 PM
Data & Collaborations to Prevent Youth Suicide
Jessica Strong, Community Health & Outreach Manager, Primary Children's Hospital, Intermountain HealthCare
Tammer Attallah, Psychiatric Program Administrator, Primary Children's Hospital, Intermountain HealthCare
Suicide is the leading cause of death for youth ages 10-17 in Utah. This presentation will examine how data has influenced the building and delivery of our three-pronged strategy of preparing the workforce, raising awareness, and improving access to treatment, in youth suicide prevention.

Our initial work has been in preparing the workforce to screen, triage, refer and treat adolescents with suicidal behavior. National studies show only 40-50% of psychology graduate students receive formal training in suicide risk assessment and management, nearly 90% of mental health professionals would like to improve their competence in this area, and only 37% of Utah mental health professionals felt they had received adequate training to engage and assist patients with suicide-related behavior. We conducted original research to determine local gaps and barriers in order to select appropriate training to offer to providers. After implementing training, we are measuring self-reported confidence and competency. We are using focus groups and input from various community groups in building an awareness campaign that aligns with state efforts and focuses on positive, hopeful messages. Improving access to treatment has been informed by data by examining high areas of need, and exploring non-traditional delivery mechanisms such as telehealth.

Suicide prevention requires a community approach and we will discuss whom our partners are and how we are working to streamline our endeavors, based on community needs, preferences, and resources. Healthcare serves as an important bridge to behavioral health care in the community and Primary Children’s Hospital is taking that role very seriously as we work collectively to address a growing crisis.

Learning Objectives:
• Identify possible partners within their community to address youth suicide
• Learn where to access and build informative data about youth suicide
• Learn how a children’s hospital can increase capacity of mental health professionals in recognizing and treating suicidal youth

Measurement for Community Health Improvement Processes
Michael Stoto, Professor of Health Systems Administration and Population Health, Georgetown University
Mary Davis, Evaluation Lead, Health Resources in Action
Abby Atkins, Director of Research and Evaluation, Health Resources in Action

Hospitals are required to work with community organizations to conduct a Community Health Needs Assessment (CHNA) and adopt an associated implementation strategy. In concert with the healthcare delivery system’s transformation from volume to value and efforts to enhance multi-sector collaboration, CHNAs and other community health improvement processes have the potential to bridge efforts of the healthcare delivery sector, public health agencies, and other community organizations to improve population health outcomes. Having a shared measurement system is critical to achieving collective impact, yet our recent review of current community health improvement efforts found that despite the availability of community-level data from a variety of sources, many collaborations fall short in population health measurement and program evaluation.

In particular, we found more focus on conducting CHNAs than on implementing strategies and on monitoring efforts and evaluating the results. Correspondingly, many collaborations lack clear, measurable objectives and evaluation plans. In the second phase of an ongoing project we will identify and to in-depth case studies of approximately 10 exemplary community health improvement (CHI) processes. Based on information learned through these case studies, this presentation will suggest best practices for measurement systems with a focus on measures for needs assessments and priority setting and for monitoring collaborative implementation strategies.

We will analyze whether (1) the CHIs articulate a clear definition of intended outcomes, including promoting health equity; (2) out of the assessment comes clear, focused, measurable objectives and expected outcomes, including
outcomes that promote health equity; (3) the expected outcomes are realistic and addressed with specific action plans designed to improve population health and increase health equity; and (4) whether the plans and their associated performance measures become fully integrated into agencies and become a way of being for the agencies.

Learning Objectives:
• Articulate the need for clearly-defined population health measures in identifying priority health issues in a community
• Describe the need for performance measures in implementation plans that are fully integrated into hospitals, health departments, and community organizations activities
• Identify at least one data and measurement approach to consider to guide their own community health improvement activities