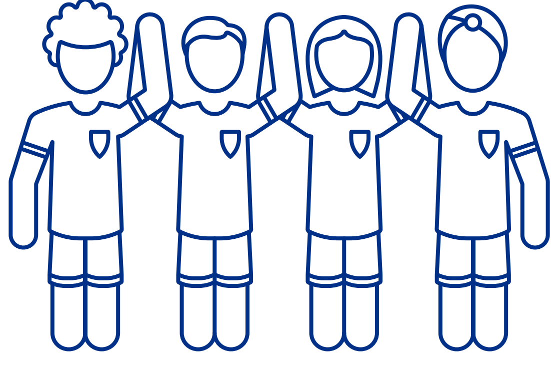
AT PROVIDENCE: WHAT GETS DONE, GETS MEASURED



CHAs are a team sport.

- Providence conducts **12 to 26 CHAs per year** across **51 markets** in **seven Western states** from Alaska to Texas.

Breaking down the responsibilities:

- **The enterprise team** provides direction, strategy, oversight, high-level process, resources and training.
- **Local hospitals** have autonomy and flexibility in execution.

The result

A data-driven, measurement-based approach that springboards community health needs into Providence's local and enterprise strategic planning and priorities.

> ***"We talk a lot about subsidiarity and solidarity. It has to be a mix of both."***
>
> Megan McAninch-Jones
> Executive Director, Community Health
> Providence

Making the model work

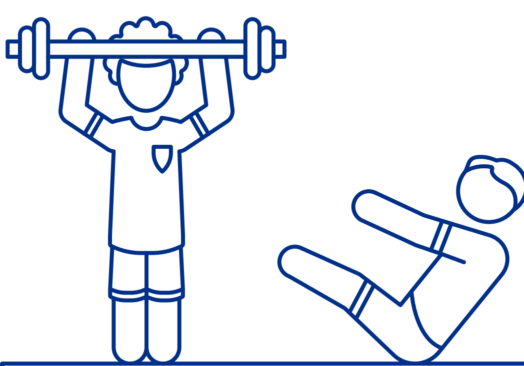
Up-to-date metrics are embedded throughout the process, enabling:

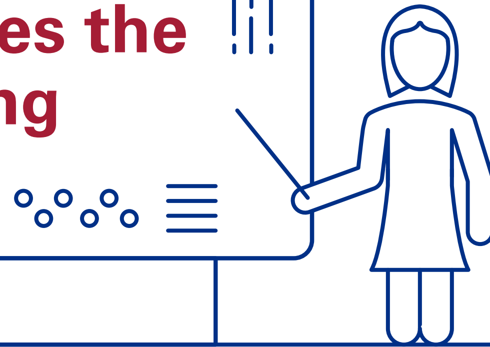
Ownership and accountability

Greater usability by communities

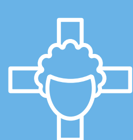
Identification of improvement opportunities

A twist on the widely known Peter Drucker principle: "What gets measured, gets done."





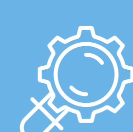
The enterprise team does the heavy lifting in crunching and presenting data:



Serves as an internal consultant for hospitals.

Collects and analyzes public data for each market.

Maintains dashboard of 26 indicators.



Conducts qualitative analysis.

Builds data hubs and visualizations.

Local hospitals use enterprise data and strategies with home-field expertise.

- **Identify populations, including hard-to-reach voices:**
  - Low-income families
  - Uninsured and underinsured people
  - Older adults
  - People in recovery from substance use disorder
  - People experiencing homelessness
- **Build relationships with community-based organizations and other partners.**
- **Gather qualitative data:**
  - CBO listening sessions with specific populations
  - Key informant interviews with politicians and public health leaders
- **Develop report of findings with high and medium priorities.**
- **Expand, adjust or develop and implement programs.**
- **Devise, track and report on program metrics against goals.**

While chronic health needs, such as housing and food insecurity, are common across Providence's system, local teams can choose how to tackle them.

- **One option is through a farmer's market:**
  - Offering a match program for produce purchase.
  - Cross-promoting through diabetes education program.
  - Assessing how many pounds of produce are sold.

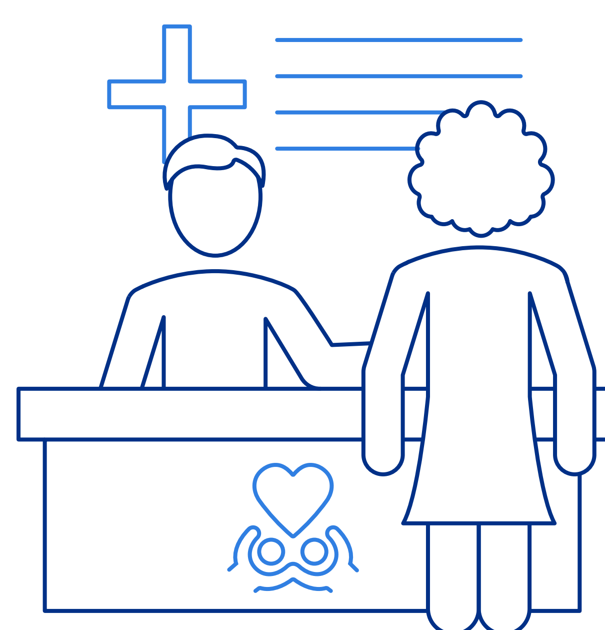
Find out more about the Providence-sponsored Wilmington Certified Farmer's Market

@WilmingtonCFM
@WilmingtonCFM

Local hospitals share their successes to inspire wider adoption throughout the system.

Example: Community Resource Desk

- Located in clinics and hospitals serving high-need patients.
- Staffed by Providence or social services agencies.
- Measures effectiveness by number of warm handoffs and referrals.



Interventions are the end game.

A playbook is used to set goals and evaluate progress:

- **Includes** all community health improvement plans.
- **Accounts** for top health-need priorities and long-term goals.
- **Starts** with baseline and two-year and three-year targets.
- **Develops** qualitative and quantitative metrics.
- **Aligns** with community health governance dashboard.

The American Hospital Association's Community Health Assessment Toolkit offers a nine-step guide for hospitals and health systems to collaborate with their communities and strategic partners to conduct a community health assessment (CHA) and meet community health needs assessment (CHNA) requirements.

Find the toolkit at: healthycommunities.org/resources/community-health-assessment-toolkit