HPIO All Hands on Deck Roundtable Take-away Results

May 13, 2015

Event description

On April 29, 2015, HPIO hosted an event in partnership with the Ohio Department of Health, the Ohio Hospital Association and the Association of Ohio Health Commissioners titled "All hands on deck: Navigating partnerships in population health planning" (see full agenda here). The purpose of the forum was to explore the role of hospitals and local health departments in population health planning through hospital Community Health Needs Assessments and Implementation Strategies (CHNA/IS) and local health department Community Health Assessments/Community Health Improvement Plans (CHAs/CHIPs). Following the forum, HPIO hosted a series of roundtable discussions to identify ways that hospitals and health departments can work together and to identify tools that may help to improve efficiency and collaboration for CHNA/IS and CHA/CHIP projects.

Roundtable process

There were four 20-minute roundtable sessions. Each session addressed one roundtable objective, listed below. Facilitators were assigned to a table and remained at the table for the duration of the Roundtable discussions. Participants moved to new tables between rounds, and were assigned to have participants from a mix of sectors (LHDs, hospitals, other sectors) at each table. There were 17 tables and facilitators total.

Roundtable objectives

As a result of attending, we will be able to identify:

1. Barriers to collaboration between local health departments (LHDs) and hospitals and potential strategies for overcoming those barriers.
2. Components of the community health needs assessment (CHNA), implementation strategy (IS), community health assessment (CHA), and community health improvement planning (CHIP) processes for which LHDs and hospitals are most in need of guidance (e.g., data sources, prioritizing, evidence-based strategies, IRS/PHAB compliance, collaboration and trust, etc.).
3. Types of tools that might help to improve efficiency and collaboration (e.g., common templates, checklists, menus of priorities or strategies, etc.)
4. Role that state-level organizations such as HPIO, OHA, AOHC, and ODH could serve to better support hospitals and LHDs in their CHNA/IS/CHA/CHIP processes.

Notes

1. Although there were 113 participants registered for the roundtables, only 54 were present at the roundtable session, in addition to the 17 facilitators. As a result, some tables combined with another table during certain rounds, in order to have more people at the table. Number of tables participating in each round is indicated below.
2. While there were a fairly equal number of hospitals and LHDs registered for the roundtables, more LHD participants than hospital participants were actually present (30 LDH participants, 16 hospital, 8 other).
3. In some cases, tables identified more than three top take-aways. These additional responses were counted for the purpose of this report.

Take-away results

Objective 1: Identify barriers to collaboration between local health departments (LHDs) and hospitals and potential strategies for overcoming those barriers.

13 tables

Exhibit 1. Top 3 barriers for hospitals

Most common response categories*	Number of tables making this suggestion
Timeline difference – 3 year hospital cycle vs. 5 year LHD cycle	7
Lack of resources or capacity – staff, money, time	6
Lack of understanding of population health/public health/community health definitions or perspective	5
Competition, particularly hospital market competition	5
Concerns about IRS compliance	4
Regional/local characteristics and differences (e.g. number of hospitals or LHDs in region, hospital/LHD size and population served, differing health needs locally than in region)	4
Lack of trust or communication; Fear of collaboration	4
Having decision makers at the table; Involving the right people	3

*Suggestions offered by three or more tables

Exhibit 2. Top 3 barriers for LHDs

Most common response categories*	Number of tables making this suggestion
Lack of resources or capacity – staff, money, time	8
Timeline difference – 3 year hospital cycle vs. 5 year LHD cycle	6
Having decision makers at the table; Involving the right people	4
LHDs don't know hospital folks, Hospitals don't know LHD folks	3

*Suggestions offered by three or more tables

Exhibit 3. Top 3 potential strategies to overcome barriers

Most common response categories*	Number of tables making this suggestion
Timeline difference – 3 year hospital cycle vs. 5 year LHD cycle	5
Outside facilitator/neutral convener	5
Shared leadership (e.g. sitting on each other's boards, "cross pollinating" governance)	5
Funding for collaboration (incentivize/reward collaboration, state funding for collaboration)	4
Make documents comparable (e.g. common templates, state template for assessment questions and priorities)	3
Regionalization/regional cross-jurisdictional sharing and collaboration	3

*Suggestions offered by three or more tables

Eleven of the thirteen groups pointed to the different timelines – 3 years for hospitals, 5 years for LHDs – as a major barrier to LHDs, hospitals, or both, and suggested synchronizing the assessment cycle. Groups suggesting synchronization generally wanted to use the 5 year cycle for both, and recognized that this would require a change by the IRS or other government entity.

Having decision makers at the table and a lack of resources were also barriers for both hospitals and LHDs. Groups suggested funding for collaboration, having a neutral convener and having shared, "cross pollinating" leadership as potential solutions.

Barriers for hospitals also included barriers to collaboration with LHDs (lack of understanding of population health/public health/community health perspective), barriers to collaboration with hospitals (market competition), and barriers for both (regional/local differences, lack of trust and communication).

There was more spread in the responses offered for LHDs' barriers, compared to the higher consensus across groups about hospital's collaboration barriers. In addition to the barriers listed above, one or two groups mentioned LHD concerns about compliance, differences in regional/local characteristics, lack of trust or communication, and a lack of understanding of population health/public health/community health perspective as barriers to collaboration.

Although several groups suggested regionalization as a solution to some of these barriers, it is worth noting that some participants were not in favor of regionalization. In this and later rounds, some groups noted that regionalization threatens local autonomy and may result in the needs of local populations being trumped by regional concerns, and therefore going unaddressed.

Objective 2: Identify components of the CHNA/IS/CHA/CHIP process for which LHDs and hospitals are most in need of guidance.

16 tables

Exhibit 4. Top 3 most challenging components

Most common response categories*	Number of tables making this suggestion
Collaboration and trust	9
Collection of secondary data	8
Compliance with IRS/PHAB requirements	6
Collection of primary data	5
Process for community engagement and input	5
Developing measurable outcomes and time-framed targets	5
Evaluation and continuous quality improvement efforts	5
Proprietorship/proprietary data, transparency	5
Lack of resources or capacity – staff, money, time	3
Identifying and implementing evidence-based strategies	3

*Suggestions offered by three or more tables

Between collection of primary, secondary and proprietary data, the data collection categories were considered the most challenging to the most participants, with 12 of 16 tables listing one or more of these challenges. Two tables also noted the lack of resources and skills necessary to analyze and "drill down" into the data. Several solutions were suggested in the next two sections to address these concerns.

Following the data collection categories, collaboration and trust was the second most challenging component of the CHNA/IS/CHA/CHIP process for LHDs and hospitals. In addition to the nine groups who listed it explicitly, some groups also noted the challenge of proprietorship and transparency with data, particularly hospital utilization data. Some group responses suggested that this struggle in data sharing is related to issues of trust and market competition.

Numerous other challenging components were noted, from a variety of steps in the CHNA/IS/CHA/CHIP process: compliance with IRS/PHAB requirements, process for community engagement, developing measurable outcomes, evaluation and continuous quality improvement, and identifying and implementing evidence-based strategies. This suggests a need for a comprehensive set of tools and guidance for the process. In fact, this characterized many of the suggestions that emerged in rounds 3 and 4 (see below).

Objective 3: Identify types of tools that might help to improve efficiency and collaboration.

16 tables

Exhibit 5. Top 3 types of tools for efficiency and collaboration

Most common response categories*	Number of tables making this suggestion
Guidelines for collaboration, including list of who to bring to the table/types of community partners	11
Data sources	9
Common templates for assessment and/or plan documents	7
Measures for effectiveness/impact/return-on-investment	6
Networking opportunities, regular meetings/forums/discussions	6
Outside facilitator, neutral convener	3
Repository for recent Ohio CHNA/IS/CHA/CHIP documents	3
Common template for data collection, standard assessment questions	3

*Suggestions offered by three or more tables

Participant groups were most interested in guidelines to collaboration, particularly lists of who to bring to the table. There were two themes in the suggestions of potential partner lists. One was the challenge that hospitals and LHDs don't know each other's people, and therefore would like a resource indicating who to reach out to. The second theme was a need for list of public health schools and academic consultants in the state, to help with the challenges such as data collection and analysis. One group even suggested that public health schools could be incentivized or required by the state to provide CHNA/IS/CHA/CHIP-related services at no charge to LHDs and hospitals.

Groups mentioned a desire for tools around data sources, including lists of relevant data sources, lists of data sources for social determinants of health, and means to access data "from the other side" (LHD access to hospital data and vice versa). Groups also wished to see more timely and local data.

Participants also wanted to see tools that would make CHNA/IS/CHA/CHIPs more comparable to each other. Specific suggestions included common templates for assessment/plan documents, structure guides, component/compliance checklists, and a repository of recent documents to serve as examples. Groups also mentioned a desire for a common template of survey questions for primary data collection, with a list of required question plus a list of supplemental questions for hospitals/LHDs to choose from. They suggested that this would allow documents to be comparable across the state, but also leave room for digging into more localized needs.

Objective 4: Identify role that state-level organizations such as HPIO, OHA, AOHC, and ODH could serve to better support hospitals and LHDs in their CHNA/IS/CHA/CHIP processes.

11 tables

Exhibit 6. Top 3 things state-level organizations can do to better support hospitals and LHDs

Most common response categories*	Number of tables making this suggestion
Provide access to data sources, create or collate data	7
Create and disseminate guidelines for collaboration, list of who to bring to the table/types of community partners	6
Facilitate networking opportunities, regular meetings/forums/discussions	6
Act as outside facilitator, neutral convener	3
Create "one stop shop" for templates, documents, data, etc.	3
Act as state or national level connection for communication and education activities	3

*Suggestions offered by three or more tables

As mentioned under Objective 2, data collection and access was a major challenge to the assessment process. In the final round, the majority of groups suggested that state-level organizations could provide access to data, either through collating or filling gaps in existing data. Participants hoped to see various data sources brought to one place, including data sources that have been harder for LHDs to access, like hospital utilization and managed care data. Participants from less populous counties also pointed out that getting local-level data is more costly for them, since their areas are often too small to have accurate data available through free sources.

Participants again mentioned interest in guidelines for collaboration and lists of potential partners, suggesting that state-level organizations could create and/or disseminate such documents.

Groups also hoped to see state-level organizations facilitate collaboration and potential partnerships. Suggestions for state-level organizations included hosting regular networking opportunities such as meetings and forums, as well as acting as neutral facilitators for collaboration in the CHNA/IS/CHA/CHIP process.

Finally, participants wanted to see the resources here and the tools from Objective 3 collected into a "one-stop shop" for all their CHNA/IS/CHA/CHIP needs.