History of Collaboration

- Previous community health assessment 2000
- Jointly established FQHC 1999
- Elementary school obesity project
- Numerous community health initiatives eg. Lyme Disease, caccooning project, etc.
Current Collaboration

- Community Health Assessment 2012
- Community Health Improvement Plan 2013-2016
- Various projects
  - Homelessness
  - Education
How Did We Engage the Community?

- Chose ACHI model prior to engaging group
- Created compelling story
- Brainstormed who we needed, who knew who
- Personal calls to personal contacts
- Followed up with letter outlining process
- Asked community who else should be at table

Respect for their time was key
Initially 40 members from 30 organizations
Representing health care, public health, education, public safety, mental health, social services, business, senior services, elected officials, and transportation, seniors, youth
Task Force continued to expand and diversify as the project progressed
225 unique individuals engaged includes community residents and representatives from organizations.
Tools for Engagement

- On-line tools (Constant Contact) for Core Leadership
- Personal letters
- Telephone calls
- Site visits
- Focus Groups
- Interviews
- Ongoing meetings
- Organization structure established
Defined Core Team Roles

- Coordinate overall assessment process
- Motivate community organizations and community members to participate
- Hire consultant to collect/analyze primary data
  - RFP development (Health Department)
  - RFP release and coordination of applicant selection (Hospital)
- Pay for majority of assessment costs (Hospital)
- Recruit and manage focus groups & interviews
- Collect primary & secondary data
- Analyze secondary data (Health Department)
- Motivate community to act on priority issues
- Recruit CHIP workgroup participants
- Continuous media outreach (Hospital)
- Continuous partner electronic communications (Health Department)
Identified Task Force Roles

- Provide quantitative & qualitative data
- Identify additional secondary data sources
- Provide input on qualitative data collection
- Motivate and recruit community members
- Participate in focus groups & interviews
- Assist in organizing and conducting focus groups
- Provide technical assistance in areas of expertise
- Identify priority issues for health improvement
- Participate in CHIP development and implementation
Explored Health Equity

- Engaged representatives from multiple sectors influencing health, such as education, housing, business development, transportation, and public safety.

- Synthesized secondary data on social, economic, and health indicators in the region and primary qualitative information.
  - Utilized US Census, County Health Rankings and utilized Health Equity Data.

- When possible, analyzed data to determine who is impacted most (disparities and inequities) and what changes occurred over time (trends).

- Analyzed quantitative data to determine how it matched up with community member perceptions.
Aligned with National Initiatives

- Healthy People 2020 benchmarks
- National Prevention Strategy priorities
  - Preventing drug abuse and excessive alcohol use, healthy eating, active living, mental and emotional well-being
- CDC Winnable Battles
  - Nutrition, Physical Activity, Obesity

Source: Behavioral Risk Factor Surveillance System (BRFSS), 2010
**relevant Healthy People 2020 Target, not available
Set Up CHIP Working Structure

- Norwalk Hospital Board of Trustees
- Community Health Committee
- Norwalk Department of Health Board
- Obesity Initiative Committee
- Greater Norwalk Opening Doors
- Mental Health/Substance Abuse Initiative Committee
- Physical Activity
- Nutrition
- Resource Guide
- Coordinated Care Team
- Housing
CHIP 1: Mental Health/Substance Abuse

- Goal: Provide education and access to quality, evidence-based mental health and substance abuse prevention, intervention and treatment services.

- 36 Top ED utilizers visited 1100 times
  - 16 had 708 visits – alcohol
  - 5 had 209 visits – psychosis
  - 9 had 171 visits – pain

- 30 patients admitted 1100 times
CHIP 2: Obesity/Healthy Lifestyle

- Goal: Prevent and reduce obesity in the community by promoting healthy lifestyles.

- Goat trails
- Food deserts, fresh markets
- Walk to school
- Reduce BMI
CHIP 3 (sort of): Opening Doors

- Goal: To provide individuals who are homeless the highest standard of care and supportive services to enable their transition to self-sufficiency within a non-shelter permanent residence.

- Coordinated Care Team
- Housing vouchers
- CDBG Grant - staff
Challenges

- Costly – time & money
- Staff capacity
- Other large-scale community projects being conducted concurrently
- Scarce local quantitative data
- Striking a balance between community-driven strategy selection and ensuring strategies are feasible, aligned with national recommendations
Successes

- Identification of community strengths and needs
- Creating understanding of local data
- Strengthening *our* partnership
- Positioned as leaders in community
- Creating new and enhanced relationships
- High level of community interest and commitment

Silos and Barriers Shrinking
Questions