THE UNIVERSITY OF CHICAGO MEDICINE

Strategic and Sustainability Planning

For Population Health Collaborative

The Community Health Peer Learning (CHP) Program aims to advance progress toward population health improvements through the expanded capture, sharing, and use of electronic health data from diverse sectors. Engaging ten Participant Communities and five Subject Matter Expert (SME) communities in a peer learning collaborative, the CHP Program builds community capacity and supports the identification of data solutions, acceleration of local progress, and dissemination of best practices and lessons learned.

This learning guide is part of a series developed by CHP SME communities - highlighting their practical experiences, noting key lessons, and sharing insights relevant to those working as part of local initiatives to improve population health. The guides are intended to inform the ongoing work of CHP Participant Communities, as well other projects supported through a rapidly growing number of place-based health improvement initiatives. While individual guides address specific topics, such as community-wide information exchange capacity building, at their core, they also tell a story of how data infrastructure development, enabled through purposeful collaboration, can help drive better care, smarter spending, and healthier communities. We hope you find these stories to be engaging, practical, and useful!

The Office of the National Coordinator for Health Information Technology

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Contents

What is Strategic and Sustainability Planning?

A strategic plan is a tool that is used to help set priorities, determine data needs, focus resources and ensure that all stakeholders are working toward common goals and outcomes. When followed, a strategic plan allows stakeholders to assess whether the goals, objectives and metrics are being met, as well as, adjust as necessary. A strategic plan provides a roadmap for identification and development of initiatives/programs required to improve population health and considers both short and long-term goals. When entering into a collaborative relationship, stakeholders should establish a strategic plan very early on. A well-defined strategy allows for focused work, appropriate use of resources, stakeholder engagement and buy-in.

A sustainability plan can either be embedded within the strategic plan or developed separately. A sustainability plan includes steps to continue the efforts over time, and focuses stakeholders on successfully meeting objectives and fulfilling the mission and vision of the collaboration. Elements of a sustainability plan may include stakeholder support, pooling/coordinating skills and respective organization assets, operational infrastructure, financial and human resources, flexibility to make changes as the health care environment changes and evaluation.

Sustainability of any initiative depends on the successful execution of a carefully planned strategic plan and good collaboration. The sustainability plan can easily become the follow-up plan to the strategic plan, guiding work for the next 3 – 5 years. Sustainability must be considered while developing your strategic plan; ideally, it should be baked into the strategic planning process from beginning to end. Strategic and sustainability planning is important to ensure that the population health initiative is goal oriented, effectively executed, and leads to maximum impact.

Developing the Strategic Plan

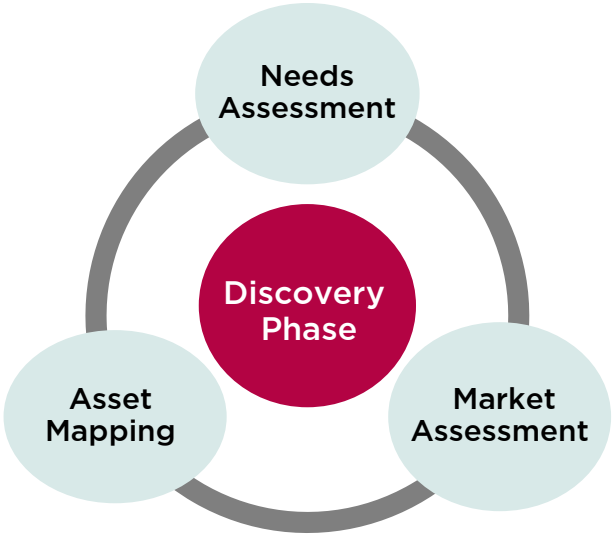
The strategic plan helps to address critical needs and identify solutions to meet these needs. When developing a population health strategy, these important steps will provide important data and a realistic focus to ensure that the strategic and sustainability plan will be achievable. Several important steps that should be considered prior to beginning the strategic and sustainability planning process include: understanding the needs by way of a needs assessment, determining if environmental factors may impact the availability of resources - a market analysis and understanding the community assets to support the plan. These steps comprise the discovery phase (Figure 1).

Needs Assessment

A needs assessment identifies challenges of the target population, existing resources available to address these challenges and informs the strategic priorities. The most important activity of the needs assessment is gathering information from the target population by reaching out directly to them, or to stakeholders whose efforts contribute to supporting the target population and who understand the needs of the community, i.e., health care providers, faith leaders, social services and civic agencies, etc.

A needs assessment can be accomplished via quantitative methods,

Figure 1. Elements of the Discovery Phase



such as a formal survey or analysis of electronic health records data,[1] as well as via qualitative research such as focus groups and key informant interviews. It may not always be necessary to conduct your own needs assessment. If a formal needs assessment is not feasible, existing data sources should be considered. These include the National Health Interview Survey, Behavior Risk Factor Surveillance System, and the Community Health Needs Assessment available from non-profit hospitals, etc. Local public health departments are one of the best sources of data and when available, can provide granular data analyses based on the target population.

The needs assessment is also important to ensure the initiatives or programs you intend to implement provide the most value for your target population. When seeking agreement among stakeholders on appropriate population health interventions, the needs assessment provides an unbiased data source that can help direct decisions particularly when there is competing interest between the collaborators. Identifying the need of your target population based on the most current data is an invaluable first step in developing your strategic plan and supporting a sustainability plan. The needs assessment will provide basis for interventions necessary to overcome the population health challenges.

Market Assessment

A clear and accurate understanding of market dynamics is a critical element for the successful development and implementation of a population health management strategy/initiative. Market dynamics are driving forces that impact the feasibility of successfully implementing a strategic plan. Some important market dynamics that should be considered in a market assessment are the evolving health care landscape, changes in local, national, state regulatory/policies, payer reimbursement changes, patient/consumer trends, etc.

San Diego Health Connect Market

With a combined population in excess of 3.2 million people, San Diego County is ranked the second most populous county in California and the fifth most populous in the United States. The military has a large footprint in the County and is home to 3 military hospitals. San Diego also has 18 federally recognized Indian Reservations and a large Latino population. The health care landscape includes 19 acute care hospitals, 4 non-acute rehab hospitals and over 115 clinics. There are a number of large Integrated Delivery Networks (IDNs), which account for more than 65% of health care in the County, however, no one IDN has more than a 25% market share.

San Diego Health Connect (SDHC) is the community HIE connecting all the IDNs, Veterans Affairs (VA) Medical Center, Department of Defense (DoD), County Health and Human Services, EMS and many large and small physician groups – over 35 participants total. Despite the unique challenges presented by a diverse population, SDHC has properly identified over 3.2 million people and can access health care records from 19 of the 23 acute care hospitals, as well as, 15 of 17 FQHCs.

The San Diego health care setting is highly competitive with large provider organizations (Kaiser Permanente, Scripps Health, and Sharp Healthcare), a substantial federally covered population (VA Medical Center and Naval Medical Center San Diego – one of the largest DoD medical centers in the country), and a network of community clinics and unaffiliated, independent private practice physicians and providers. Accordingly, establishing a communitywide governance in this competitive marketplace was of paramount importance to the HIE's success and long-term sustainability.

[1]The 2015 Edition Health Information Technology (Health IT) Certification Criteria, Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications Final Rule includes certification criterion to enable a user to record, change, and access a patient's social, psychological, and behavioral information, including patient data on financial resource strain, education, stress, depression, physical activity, alcohol use, social connection and isolation, and exposure to violence (i.e., intimate partner violence). See also: 2015 Edition Certification Companion Guide and 2015 Edition Final Rule: Addressing Health Disparities.

Asset Mapping

Understanding what resources or community assets are available to enable the population health strategic plan is an essential step. The feasibility of achieving the plan's goals and objectives is impacted by the resources or assets that are needed. Execution of an effective population health management initiative relies on the community assets. The stakeholders should build time to determine community assets into the strategic planning process. Leveraging these assets to achieve the overall strategic plan can help to control costs, minimize waste and duplication, and create more effective use of time and effort. When necessary assets are unavailable, the strategic plan should include either building or acquiring these assets. The asset or solution should be built by a group of individuals who have a similar vision for population health, and have a vested interest in meeting the needs.

Building and Leveraging Community Assets

The South Side Healthcare Collaborative (SSHC) is a network of over 30 Federally Qualified Health Centers, Free and Charitable Clinics and Community Hospitals. These provider organizations are located across the south side of Chicago. The SSHC focuses on advancing the capabilities of its members, through service, education, networking and advocacy. UCM's membership within the SSHC lends UCM an opportunity to partner with other health care providers on the South Side of Chicago in improving the health of populations within our community.

The SSHC was established in 2005 under the auspices of University of Chicago Medicine's Urban Health Initiative (UHI). At that time, many patients who presented in the UCM emergency department had no primary medical home. The UHI leadership determined that in order to ensure patients had a place for ongoing and continuous care there was a need to collaborate with the primary care medical home network on the South Side of Chicago. These primary medical home providers were FQHCs and free clinics. The SSHC was birthed out of this need. The primary program supporting the collaborative at that time was the Medical Home Connect program that linked ED patients without a primary medical home to one of the community health centers on the South Side. Since that time, the SSHC has evolved to be one of the most vital community assets to facilitate many population health initiatives. Currently, several UCM programs and initiatives focused on care delivery, community benefit, access to health, physician residency training, and faculty research are executed through the SSHC partners. Additionally, because UCM recognizes the collaborative as an invaluable community asset, UCM provides an Executive Director and administrative staff to oversee the day-to-day functions of the SSHC.

Elements of an effective strategic plan

The strategic plan functions as the most essential tool for making guided decisions throughout the lifetime of a population health initiative. The market and needs assessment will provide a better understanding of the current state of population health challenges in the community. Assessing community assets will enable stakeholders to determine if all of the resources are available to execute the strategic plan. The strategic plan will inform stakeholders on what is needed to bridge the gap between the current and ideal state.

Figure. 2 Strategic Planning Steps

Several important steps are standard and should be considered when developing the strategic plan (Figure 2). These include:

1. **Identify goals and objectives.** Data collected during the discovery phase will help to reveal what goals and objectives should be considered. For example, if the needs assessment shows a high prevalence of pediatric asthma hospitalization, the goal would center on reducing asthma hospitalization. Determining the goals and objectives will enable stakeholders to set priorities for designing a solution to the population health challenge.

Objectives should be SMART:

- *Specific* – target a specific area for improvement
- *Measurable* – quantify or at least suggest an indicator of progress
- *Achievable* – attainable or feasible
- *Realistic* – state what results can realistically be achieved, given available resources
- *Time-bound* – specify when the result(s) can be achieved

2. **Prioritize goals.** Priority should be given to goals that provide the most value to your stakeholders and the target population.

Some questions to consider while identifying priorities are:

- What gaps or variations exist that need to be addressed?
- Which gaps/variations need to be addressed first and will result in the greatest impact?
- Are there existing programs/initiatives addressing these gaps?
- Are the existing programs/initiatives effective?
- Are they leveraged in our solution?
- What is the feasibility of achieving the goals/objectives?
- Are new programs needed?
- What initiatives should be expanded, and when?
- What is the return on investment (ROI)?

3. **Write a charter for your overall plan that identifies the main goal(s) of the plan.** Charters specify the scope of work and desired outcomes for the strategic plan. It should also identify collaborators, individuals or organizations that will be necessary for executing the plan. The latter is referred to as interdependencies. Main objectives of the plan should be identified in the charter as well as the overall goal/metric that the plan is intended to accomplish. Based on the scope of work, leadership and workgroup members will document a detailed work plan which will be used as a roadmap to guide the

activities necessary to obtain desired outcomes. Ideally, each objective of the strategic plan should have a separate charter if there is a work plan tied to it.

4. **Design solutions/initiatives based on priorities and available resources to address identified issues.** Once priorities have been set, initiatives should be designed to achieve the goals and meet the priority needs of the population. Design phase should also consider data sources, capacity of health information technology (health IT), and the ability to share and exchange data for the initiative being designed. Work plans should be developed at this stage, laying out the step-by-step actions and timeline for achieving the goals.

5. **Build a framework that illustrates a systematic process and visual way to understand the pathway to the expected outcomes.** When explaining a plan to develop a population health management strategy to stakeholders, it is helpful to create a visual framework. A visual framework can help stakeholders conceptualize how resources are used, activities are executed, and outcomes – short, medium and long term, are achieved. A logic model is such a framework. Other frameworks include program matrices, process maps, community action plans and journey maps.

The Urban Health Initiative uses a logic model (Appendix B) to illustrate processes and outcomes. The logic model should display:

- Needs based on research and gap analysis
- Inputs required to address identified needs (funding, staff, partners/collaborations, infrastructure)
- Activities required to address the needs
- Outputs of activities
- Tools needed to evaluate the program activities
- Expected outcomes of activities
- The ultimate impact of the initiative

6. **Develop an Evaluation Framework.** Developing an evaluation framework during the strategic planning process is an absolute necessity for accountability, oversight and continuous quality improvement. The evaluation framework will include metrics, benchmarks, tools, databases and analytic needs. As indicated earlier, your goals must be SMART. Metrics should arise from SMART goals. The metrics that you set will indicate success or failure of the strategic plan. Along with setting metrics, systematically evaluating the progress of the planned activities toward goal achievement will help to avoid unexpected pitfalls. Systematic evaluation of the plan and activities will provide insight into whether stakeholders need to re-direct, adjust or cease a particular activity. These steps in the strategic planning process are pivotal.

7. **Establish a governance structure around the strategic plan.** Generally, strategic plans are overseen by an infrastructure that governs it. A governing structure is important regardless of how formal or informal is the entity forming the strategic plan. The governing body helps to ensure that the strategic plan is effectively executed and provides oversight as well as accountability for the efforts laid out in the plan, including data collection or data sharing initiatives. Often in collaborative relationships, members of the governing body also participate in the execution of the strategic plan. Some members lead work groups/committees tasked with executing the strategic plan. These work group leaders keep the entire governing body updated on the progress of the strategic plan.

Governance Structure

The SSHC is a collaborative partnership with a formal governance structure. It has a Board of Directors that provides leadership and oversight, and committees that plan and execute initiatives. The SSHC Board of Directors hold leadership roles with hospital systems, community health centers and free and charitable clinics that provide or promote the delivery of health care services to low income, uninsured and vulnerable populations. Committees are comprised of staff from membership organizations. This structure enables active engagement from all member organizations as initiatives are carried out. SSHC members are non-compensated volunteers who value the opportunity to make a positive impact on our community's health.

Strategic planning is a critical component of any population health initiative. It requires collaborators to be thoughtful about the future of the work at hand. It requires stakeholder commitment, and provides the roadmap for success. Sustainability planning requires detailed planning around what is necessary to ensure program success overtime. Combining strategic and sustainability planning under one umbrella strengthens the potential for success into the future.

Sustainability Planning

Sustainability planning should begin early in the collaboration's strategic planning efforts. Ideally, soon after the collaborative partnership has been formed and stakeholders have convened to work together on a population health issue, the stakeholders should begin the strategic planning process. As stakeholders move through the planning process, it is imperative that sustainability be considered and planned for.

Sustainability is not automatic and relies heavily on the success of your strategy. Some of the same elements that are a part of a good strategy – identifying goals, assessing risk, building and maintaining positive relationships – are important to your group's sustainability. Sustainability planning is an inherent part of strategic planning. Creation of a sustainable population health initiative should always be in mind during the development and execution of your strategy. Your needs assessment, market assessment, strategic plan, charter, work plan, logic model, and other tools that provide ongoing oversight into the group's activity and achievements will be your roadmap for sustainability. When planning for sustaining a collaborative initiative the following elements should be considered.

Flexible Programming

When designing programs, it is important to ensure that initiatives can be tailored to suit the needs of individual member organizations. This provides the option for adaptability, ultimately yielding greater membership engagement and added value. From the beginning, stakeholders should acknowledge that one size does not fit all members or organizations in the collaborative. A sustainability plan should be flexible to accommodate the needs of the collaborative organizations. Standard practices and procedures are necessary for consistency. However, there is a need to leave room for autonomy based on the needs of unique organizations.

Flexible Programming and Power of Inclusion

As part of UCM's effort to address childhood asthma on the South Side of Chicago, UCM implemented the Asthma Community Health Worker Program (CHW Program). The community health workers' (CHW) efforts are directed to high risk pediatric asthma patients within the SSHC. Patients of the SSHC partners are referred to UCM's Asthma Community Health Worker Program. Although the program was designed as a referral program, it was quickly realized that some flexibility in structure was necessary to ensure successful implementation of this program.

St. Bernard Hospital is a community hospital and Beloved Family Health Center (Beloved) is an FQHC, both of which wanted their patients to be enrolled in the CHW Program. However, the way in which the CHW program was implemented at each site varied according to the site's needs. St. Bernard Hospital already had an asthma educator in the emergency room and an Asthma Clinic dedicated to meeting the needs of asthma patients. It was identified that because these structures for engaging high-risk patients already existed, St. Bernard would refer high-risk patients from the Emergency Room or from the Asthma Clinic to the CHW on an as-needed basis. As the CHW receives a referral, they make appointments to visit the client at their home and provide comprehensive asthma education along with an environmental assessment.

At Beloved there were no formal structures in place for asthma care aside from the pediatricians who provide brief asthma education as they encounter pediatric asthma patients. Beloved shared that they want all of their asthma patients to receive comprehensive asthma management education and that referral is not effective because asthma patients may not come back for care until an asthma exacerbation. Recognizing Beloved's unique needs, the CHW was physically located at Beloved. In this structure the CHW received a list of all patients diagnosed with asthma and began engaging patients. The CHW at Beloved had three roles: phone call outreach to asthma patients, asthma management education in the clinic (via appointment or referral), and home visit and assessment of environmental triggers. Including the partner's voice led us to build flexibility into the CHW Program and allowed UCM to identify the most effective way to complement the continuum of care at each site.

Use timely and effective communication to manage stakeholder relationships

When addressing population health challenges, stakeholder collaboration is one of the greatest strengths. Putting in place processes to enable effective and timely communication is essential to keeping collaborative members engaged in the population health strategy and fostering an environment of trust among collaborative members. The collaborative leaders must be intentional about regular and ongoing communication with stakeholders. Many channels can be used for regular and ongoing communication. Some of these include regular meetings, hosting retreats, email updates, sharing program outcomes and challenges, etc. The goal is to create an environment where everyone feels they can freely share and receive information.

The power of inclusion – every partner has a voice

The power of a successful population health management strategy is to be inclusive and hear the voices of your stakeholders and community members. Understanding the needs of your partners, including their priorities and pressures, is integral to creating a mutually beneficial and satisfying collaboration to address population health needs. It is important for the lead organization in a collaborative partnership to be intentional about gaining an understanding of the partner organizations. Also, including the subject matter experts from partner organizations in the strategic planning process is an imperative. Engaging the partners is important and helps members feel their input and presence are valued. As such, continually assessing partner participation to ensure member engagement is essential.

This can be done by:

- Noting meeting participation, including agreeing early on with members to report their intent to miss meetings and following up with those who are absent to inform them that they were missed and the group looks forward to seeing them next time.
- Hosting retreats focused on strategic planning, engagement and team building if possible.
- Hosting regular feedback sessions with members to find out what additional programs or services are needed to be more effective.
- Solicit member input around new prospects who might bring value or a fresh perspective to the efforts of the collaborative partnership.
- If possible, assign a point person from the leading organization to be the liaison between partner organizations and to support the relationship.

Identify and manage conflict quickly

Conflict may arise in the stakeholder collaboration. Conflict can shift focus from the work of the collaboration and erode the foundation of trust among partners. When identified, it should be addressed as soon as possible. The most effective way of addressing conflict is to develop a problem resolution methodology. Once you become aware of a conflict, your problem resolution methodology must immediately be implemented to mitigate it. This methodology outlines an effective way to identify and manage conflict while maintaining healthy group relationships. At the point of awareness that a conflict may be brewing, it is important that a group leader gains an understanding of the details of the conflict. In order to gain perspective, holding individual conversations with those engaged in a conflict is helpful. Based on the findings and facts surrounding the conflict, the leadership team should work with members of the collaboration to address the conflict or concern and determine the best way to move forward. Throughout this process, remain focused on the work at hand. When you can show stakeholders what the group can accomplish through partnership, skepticism and/or conflict naturally wanes.

Manage turnover in the collaboration by effectively onboarding new members

Developing a process for knowledge transfer when a stakeholder leaves the collaborative ensures that critical information is documented and available to share with new collaborative members. Having a well-defined governance structure and clear guidelines for documentation of all information and knowledge supporting the work of the group will decrease the loss of information as membership changes overtime. Historical documents, plans and activities, meeting minutes, strategic planning outcomes and the like should be housed in a common place and accessible to leadership.

Properly onboarding the new collaborative member should include meeting with him/her personally and providing him/her with your group's history, mission and vision. Any documents and processes that the new member can reference can make him/her more comfortable and enable to engage with the group more quickly. Providing optimal support for new members is important. Steps such as assigning a point of contact who can answer questions or direct the new member to resources can be helpful when mitigating the time lost when new members join the group.

Project Extension for Community Healthcare Outcomes

When SSHC members identified the need for specialty care in the community, it designed an innovative program to meet that need. A large volume of resistant hypertensive patients who needed specialty care at member clinics were waiting months to see specialists due to limited availability. As a result, UCM implemented the Project Extension for Community Healthcare Outcomes (ECHO Chicago).

ECHO Chicago is an innovative effort to expand access to specialized care for vulnerable, underserved communities. By using advanced communications technology to bring academic medical center expertise together with primary care providers on the ground, ECHO enables underserved patients to receive state-of-the-art, evidence-based care for complex chronic conditions within the familiar surroundings of their medical home. The ECHO model provides a robust, efficient and cost-effective solution to access to care.

Training primary care providers on the ground to treat prevalent specialty care conditions builds capacity of the physicians to be able to take care of their patients in an environment with limited specialty care resources. Although ECHO Chicago started with training primary care physicians to treat resistant hypertensive patients, it has evolved to include a variety of specialty areas such as childhood obesity, Hepatitis C, Risk based women's health, integrated primary and behavioral health, etc. Additionally, recognizing the value of building capacity within their health centers, more and more SSHC member organizations are joining ECHO.

Building capacity at SSHC organizations reduces wait time for patients to see a specialist (8-10months), allows a physician to take care of their patients at a higher level and address patients specialty care needs in a timely manner.

Build capacity so the work can be sustained

Capacity building is an investment in long-term sustainability.
Capacity building can occur at the operational, programmatic, financial, organizational, or community level. Engaging in capacity building activities allows collaborative partners to develop competencies and skills to effectively and efficiently execute their tasks.

Outlined below are few approaches to capacity building:

- Development of technical expertise within the organization (e.g., workshops, trainings, web-based learning)
- Community development in a form of training, workshops, financial assistance to enable the community to acquire the skillset and funding necessary to tackle community challenges.
- Partnership development and strengthening relationships between collaborative organizations to enable peer-to-peer learning and two-way flow of knowledge and expertise.

Maintaining your initiative after the funding ends

An organization has to develop a plan, execute the plan and maintain sufficient financial resources to support the plan. Collaborators on a population health initiative will inevitably experience the end of funding. When initial funding for a population health management initiative ends, stakeholders often struggle with how to maintain the good work of the initiative. Maintaining funding for an initiative requires careful planning.

As you execute your initiative, begin identifying opportunities for ongoing funding early. Demonstrating the value proposition of your initiative through outcomes data can be most helpful

when seeking funds for sustainability. Evaluating the effectiveness of your initiative based on the metrics and expected outcomes in the strategic plan can help with the value proposition. For example, if the evaluation results demonstrate that the outcomes have been met this shows value. However, the data could also show that the outcomes are not met, which might lead one to adjust the strategy when seeking ongoing funding.

Consider a diverse pool of funding from sources such as grants, individual donors, philanthropic giving, giving campaigns, corporate contributions and membership fees and dues as options to sustain funding (Appendix D). Also consider that collaborative partners may determine that the initiative is valuable enough based on outcomes to support the program/initiative long-term through other operational funds.

Managing sunsetting of an initiative

Although sustainability is an inherent part of the strategic planning process, from time to time there may be a program or initiative that has proven to be unsustainable. The lack of sustainability may be due to limited resources, undesirable outcomes, reprioritization and the like. Evaluating program outcomes over time is key to determining its success. A major part of settling on a program or initiative is determining how to measure effectiveness. Identifying desired outcomes, key metrics and evaluation protocols are a critical component throughout the life of the program or initiative. Engaging in regular evaluation of the program is key to determining the need to make adjustments along the way. Periodic adjustments may lead to improved outcomes. If this is not the case, a decision could be made to eliminate the program.

Community members, staff, and organizational processes are impacted when programs are eliminated. It is important to develop and follow a well thought out plan when ending a program. First and foremost, a work plan should be developed listing actions necessary to phase out the initiative. This plan should include timelines, task leaders, a communication plan and outreach to other stakeholders if necessary. Keep in mind that population health programs involve a variety of collaborators - patients, staff and other stakeholders. Keeping everyone informed mitigates chaos and misunderstandings. Once the work plan is complete, there should be someone earmarked to manage execution of the work plan to ensure timely follow through and a smooth transition.

Maintaining Funding

UCM's Medical Home Connection (MHC) program was grant funded in 2005. The three-year grant provided financial resources to hire patient advocates who were charged with educating emergency room patients about the importance of having a regular source of primary care and connected patients to a medical home.

After the three-year grant funding period, program outcomes were evident. Thousands of patients had been educated about the importance of developing and maintaining a relationship with their primary care provider and connected to primary care. There were also fewer emergency room visits for this population of patients as well as decreased cost. Emergency room clinical leadership were in support of continuing the program. Presenting such glowing outcomes coupled with the belief that this program was the right thing to do for the patient, senior leadership made a decision to fund the MHC program as part of the ongoing operating budget. The MHC program has now expanded to several inpatient units and proven to play a major role in decreasing readmissions and ensuring that patients are getting the right care, in the right place and at the right time.

Conclusion

This learning guide provides a framework for strategic and sustainability planning within a collaborative. The guide outlines a series of essential steps necessary to develop a strategic plan and elements necessary to continue efforts over time to sustain goal oriented, impact driven population health initiatives. Beginning a population health initiative with a clear strategic and sustainability plan with stakeholder buy in sets the organization up for success.

This learning guide was produced as a part of the Community Health Peer Learning (CHP) Program.

In 2015, the Office of the National Coordinator for Health Information Technology (ONC) awarded AcademyHealth $2.2 million to cooperatively lead 15 communities in the CHP Program. Through this two-year program, AcademyHealth is working to establish a national peer learning collaborative addressing community-level population health management challenges through expanded collection, sharing, and use of electronic data. Learn more at www.academyhealth.org/CHPhealthIT. Learn more at www.academyhealth.org/CHPhealthIT.

Appendix A. South Side Healthcare Collaborative Strategic Planning Process

The South Side Healthcare Collaborative (SSHC) engages in a strategic planning process every 2-4 years. The most recent strategic planning retreat was held in 2014. A health care consultant who was familiar with the organization and the health care dynamics on the south side of Chicago was retained to inform and facilitate the strategic planning process. Given the rapidly changing health care environment, shift to population health management and implementation of mandatory managed care, the intent was to set goals and objectives that would favorably impact patient care seeking behaviors and organizational processes and systems. The agenda and flow of the retreat was based on feedback gathered from previous SSHC Board meeting discussions, individual stakeholder conversations and areas needing attention to successfully navigate through the changing health care environment.

The retreat began with a historical overview of SSHC accomplishments followed by the purpose and agenda for the day. Participants joined breakout sessions and engaged in discussion guided by a list of thought provoking questions which resulted in the following:

- Updated mission, vision and list of values
- Development of strategic priorities
- Identification of projects and activities to support the priorities
- Establishment of a committee structure made up of staff from the various SSHC organizations
- A two year work plan

The retreat concluded with a summary of work completed and within 30 days the strategic planning outcomes were documented, distributed, and approved by the Board of Directors. Following this process, periodic progress reports were presented to the Board of Directors to ensure advancement of the strategic plan. In early 2016, the SSHC Board of Directors convened to engage in a thorough review of the strategic plan and desired outcomes. Strategic priorities were met and Board members were pleased with the process and outcomes. We are excited about our work over the past 2 years and in the beginning stages of preparing for our 2017 strategic planning retreat.

Appendix B. Sample Logic Model from the Pediatric Asthma Community Health Worker Program

PEDIATRIC ASTHMA COMMUNITY HEALTH WORKER PROGRAM LOGIC MODEL

PURPOSE: To strengthen child and caregiver's ability to appropriately manage asthma

NEEDS	INPUT	ACTIVITIES	OUTPUTS	TOOLS	OUTCOMES	IMPACT
Over 17% of children have asthma on Chicago's South Side Lack of community based education on asthma and asthma management High rates of asthma related ER visits, hospitalizations and absenteeism. Gaps in asthma knowledge, triggers, and medication adherence Asthma care focused primarily in clinical settings where environmental and social barriers cannot be addressed	**Funding** • Grants • Donor support for staff **Staff** • CHW • UCM Community Benefit Team • Asthma center team • ER and inpatient providers • Culturally component staff **Partners/ Collaboration** • UCM • St. Bernard Hospital • Beloved • Community Clinic/FQHC • Community organizations (e.g., churches) **Infrastructure** • Asthma clinic patient referral system • Data collection tools and assessments • Database to manage program data	**Clinic** 1. Educate clients and caregivers on asthma management 2. Assess clients' asthma control status and caregivers knowledge about asthma management 3. Report progress on client status from asthma management education and subsequent home visits to the clinical team 4. Follow-up with asthma clients for ongoing progress assessments **Follow Up Home Visits and Phone Calls** 1. Conduct follow up home visits and phone calls with clients enrolled into the CHW Asthma Program 2. Assess clients' asthma control status, caregivers knowledge about asthma and asthma management, and assess for environmental triggers at home 3. Provide continued education to clients and caregivers on asthma management 4. Provide caregivers information and resources to reduce/ eliminate environmental triggers 5. Provide appropriate referrals to resources available in the community **Community Outreach** 1. Engage in community outreach (e.g., schools, Pediatric Mobile Unit, churches, other community organization) to promote asthma education. 1. Collaborate with school nurses to ensure use of Asthma Action Plan *(in development)*	**Clinic** • # of asthma mgmt education sessions to patients/caregivers at asthma clinic • # of clients enrolled into the CHW Asthma Program • # of clients retained in the CHW Asthma Program • % of AAP completions for clients without AAPs **Follow Up Home Visits and Phone Calls** • # of home visits scheduled (HA) • # and % of home visits completed (HA) • # of phone calls scheduled (PR) • # and % of phone calls completed (PR) • Improvement in knowledge about asthma management • Reduce ED visits in 25% of children with asthma • Reduce hospitalization in 25% of children with asthma • Reduce missed school days and/or caregiver work days in 25% of children with asthma • Increase medication adherence in 25% of children with asthma • Reduce symptom days in 25% of children • Reduction in client environmental triggers **Community outreach** • 6 community outreach event participation in asthma education to the community • # of community members reached	• ICA • ICA • PR • ICA • ICA • HEA, PR, FCA • PR • PR • CAK • ICA, PR, FCA • ICA, PR, FCA • ICA, PR, FCA • ICA, PR, FCA • ICA, PR, FCA • HEA, PR, FCA • CHW Log • Encounter Log	1. Increased knowledge and understanding about asthma management 2. Increased number of children who have an Asthma Action Plan at home 3. Decreased rates of asthma symptom days 4. Decreased asthma related ER/urgent care use and hospitalizations 5. Decreased missed school days and/or caregiver work days 6. Decreased environmental triggers in the home use and hospitalizations	Families are informed on asthma triggers and are appropriately managing their child's asthma.

PROCESS EVALUATION ***OUTCOME EVALUATION***

Appendix C. University of Chicago Medical Center

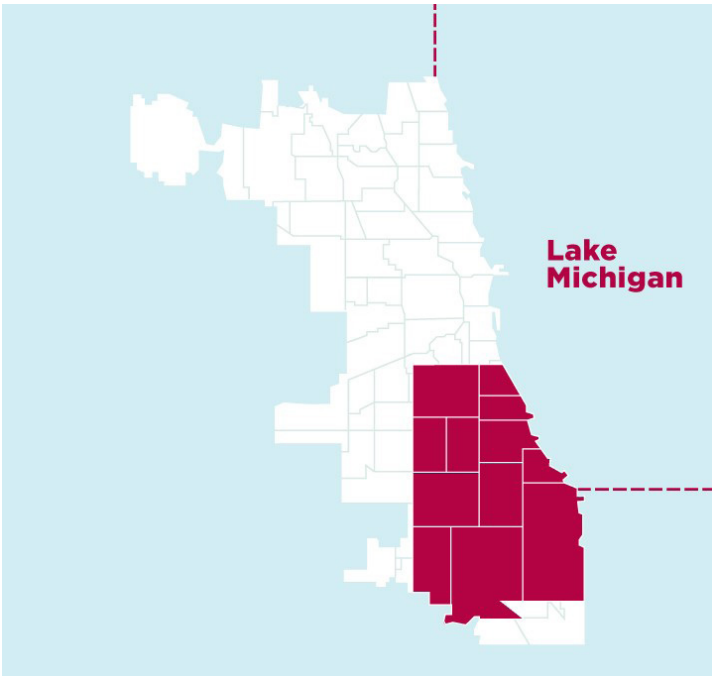
The University of Chicago Medicine and Biological Sciences, one of the nation's leading academic medical institutions, has been at the forefront of medical care since 1927. Collectively, it is comprised of the University of Chicago Pritzker School of Medicine, the University of Chicago Biological Sciences Division, and the University of Chicago Medical Center (UCMC).

UCMC's mission is to provide superior health care in a compassionate manner, ever mindful of each patient's dignity and individuality. To accomplish this mission, we call upon the skills and expertise of all of UCMC's medical professionals, who work together in collegiality to advance biomedical innovation, serve the health needs of the community, and further the knowledge of medical students, physicians, and others dedicated to caring. UCMC carries out its mission by focusing on improving the health of Chicago's South Side.

UCMC is located within the Hyde Park neighborhood on Chicago's South Side. Chicago's South Side is a storied and unique collection of vibrant, resilient, culturally rich and diverse communities. Steeped in African-American heritage and history, the South Side is marked by deep social bonds and anchored by vital community and faith-based organizations. UCMC defines its service area (UCMC SA) as 12 contiguous zip codes surrounding UCMC (see Figure A1).[2] The UCMC SA spans 31 locally defined community areas and has a population of approximately 640,000 thousand people.[3]

Currently, six out of the eleven poorest communities in Chicago are in the UCMC SA.[4] Residents in these communities face many social and economic challenges that contribute to health care inequities as compared to other areas of Chicago. Moreover, health disparities across the UCMC SA are vast as demonstrated by strikingly high rates of asthma, diabetes, obesity, breast cancer, and other chronic diseases.[5]

Figure A1. UCMC Service Area (UCMC SA)



Urban Health Initiative

The Urban Health Initiative (UHI) is UCMC's community health department through which population health management and community benefit activities are executed. The four pillars of UHI include Population Health Management, Community Affairs, Diversity, Inclusion and Equity, and Strategic Affiliations. The UHI programs and initiatives support two distinct population cohorts for which UCM has responsibility. The patient population that receive care at UCM through primary care, specialty care, hospital or ED and community population that are comprised within the UCMC SA but who may or may not get their care at UCM.

The UMC/UHI currently oversees more than 100 programs focused on care delivery, community-based education and innovation within our community. This is accomplished through collaboration with community programs and partners, innovative strategies and the utilization of resources. UHI fosters strong, lasting relationships with civic leaders, community organizations, health care providers and residents to strategically improve health and access to quality care on the South Side of Chicago.

[2]UCMC SA zip codes: 60609, 60615, 60617, 60619, 60620, 60621, 60628, 60636, 60637, 60643, 60649, 60653; [3]United States Census Bureau. Population Division. "Illinois: Population for selected ZIP Codes." *United States Census*. Washington: US Census Bureau, Census Bureau. 2010; [4]United States Census Bureau. Income Division. "Illinois: Household Income for selected ZIP Codes." *United States Census*. Washington: US Census Bureau, Census Bureau. 2010; [4]Professional Research Consultants. *2015 Community Health Needs Assessment: University of Chicago Medical Center Service Area, Cook County, Illinois*. Omaha: Professional Research Consultants, 2015; [5]Professional Research Consultants. *2015 Community Health Needs Assessment: University of Chicago Medical Center Service Area, Cook County, Illinois*. Omaha: Professional Research Consultants, 2015.

Appendix D. Funding Sources

Listed below are a few sources where community collaboratives can sign up for announcement newsletters and be the first to know when new funding opportunities are made available.

Agency for Healthcare Research and Quality (AHRQ)

Robert Wood Johnson Foundation (RWJF)

National Institutes of Health

Centers for Medicare and Medicaid Services (CMS)

Commonwealth Fund

Health Resources and Services Administration (HRSA)

Patient-Centered Outcomes Research Institute (PCORI)

California Health Care Foundation

John A. Hartford Foundation

Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

W.K. Kellogg Foundation

United Hospital Fund

William T. Grant Foundation

David and Lucile Packard Foundation

Blue Shield of California Foundation

Substance Abuse and Mental Health Services Administration (SAMHSA)

National Institute of Standards and Technology (NIST), Advanced Technology Program (ATP)

All In: Data for Community Health finds and posts new opportunities relevant to multi-sector community transformation work.

FedBizOpps.gov lists federal procurement opportunities with a value over $25,000.

Grants.gov lists competitive grant opportunities by the 26 Federal grant-making agencies.

HSRProj can be used to identify top funders of health services research.

Appendix E. Links to Additional Resources

Listed below are links to additional sources of information for concepts that were not covered in detail in this learning guide.

Assessing and Addressing Community Health Needs – Catholic Health Association of the United States. https://www.chausa.org/communitybenefit/assessing-and-addressing-community-health-needs

Community Health Needs Assessment Toolkit- Community Commons. https://www.communitycommons.org/chna/

Identifying Community Assets and Resources – Community Tool Box. http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/identify-community-assets/main

Developing Program Goals and Measurable Objectives – Center for Disease Control and Prevention. https://www.cdc.gov/std/Program/pupestd/Developing%20Program%20Goals%20and%20Objectives.pdf

SMART Objectives – Minnesota Department of Health. http://www.health.state.mn.us/divs/opi/qi/toolbox/print/objectives.pdf

Evaluation Guide: Developing and Using a Logic Model – Center for Disease Control and Prevention. https://www.cdc.gov/dhdsp/programs/spha/evaluation_guides/docs/logic_model.pdf

Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide – Center for Disease Control and Prevention. https://www.cdc.gov/eval/guide/cdcevalmanual.pdf

National Quality Forum – Improving Population Health by Working with Communities: Action Guide 3.0. http://www.qualityforum.org/Publications/2016/08/Improving_Population_Health_by_Working_with_Communities__Action_Guide_3_0.aspx