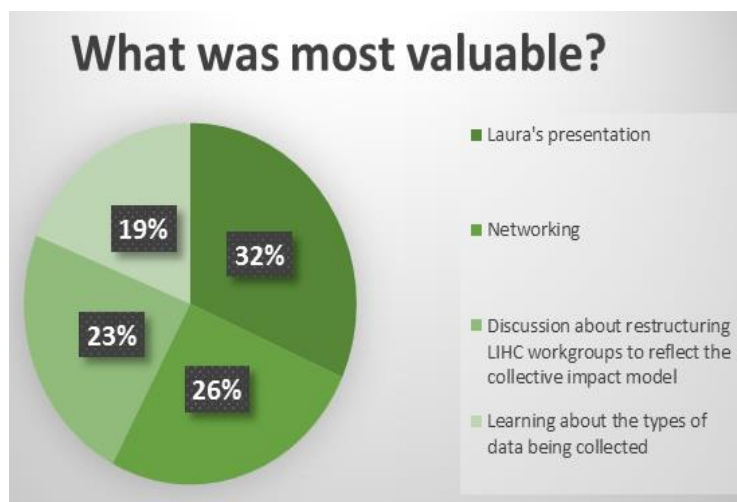# 2017

Summary of Findings

COLLECTIVE IMPACT THINK TANK

In an effort to better assess the needs of our Long Island Health Collaborative (LIHC) members, staff of the LIHC, which is the Population Health Improvement Program (PHIP) for this region, hosted a Collective Impact Think Tank to realign and restructure the flow of data and the process by which the LIHC works to support collaborative member efforts and population health activities as a whole in the region. Held September 29, 2017 on the campus of SUNY Farmingdale, the Collective Impact Think Tank introduced members to the potential of working with each other on mutually reinforcing activities and common progress measures. The LIHC plans to serve as the "backbone organization" to strengthen these mutually beneficial partnerships and to lead all partners toward collective impact.

Lead by Laura Herman, Managing Director at FSG and an expert on the collective impact model, members were first presented with the strengths of the collective impact model and shown case studies where organizations supporting each other led to more fruitful outcomes. To increase synergy, we sat participants in groups based on their organizations' social determinant of health. We then asked members to each complete a data collection template, which gathered information on major activities, metrics collected, and the process and frequency of data collection. Next, we asked that the participants discuss the data they collect within their group to find commonalities and/or complementary activities.

THE LONG ISLAND PHIP'S GOALS FOR THIS SESSION WERE THE FOLLOWING:

- **Spotlight the important community-improvement work already being conducted**
- **Share best practices across the Long Island Health Collaborative partner network**
- **Facilitate learning across groups**
- **Develop a region-specific report on Collective Impact to inform the way forward**
- **Prioritize the social determinants of health by reworking the LIHC workgroups to mirror the Social Determinants of Health**

What was most valuable?

- Laura's presentation — 32%
- Networking — 26%
- Discussion about restructuring LIHC workgroups to reflect the collective impact model — 23%
- Learning about the types of data being collected — 19%

WHAT WE LEARNED

A week after the Collective Impact Think Tank, we sent an evaluation survey via email to the 60 members who attended. 32% completed the survey. The majority of attendees found Laura's presentation to be the most valuable part of this event and applicable to the Long Island region. Based on feedback, many members felt that being more aware of the data being collected by other organizations was helpful; however, they were more interested to know how the LIHC would use the information collected during the event to move forward. Members also stated that to achieve collective impact, the LIHC needs more specific goals.

It was apparent from among the data collection templates and the conversation around the room that there is an overwhelming amount of data being collected. Questions raised included: Why is all this data being collected? What is

being done with all this data? The majority of the data relates to process and progress measures. Participants expressed and continue to express a need for outcome data.

In its current capacity, the LIHC oversees two primary data collection activities:

- **Individual Community Health Assessment Survey.** This survey collects demographic information and asks questions about individuals' health concerns and barriers to care and their perception of their community's health concerns and barriers to care. The survey is distributed in hard copy and via Survey Monkey on an ongoing basis through the efforts of LIHC partners. Nearly 10,000 surveys have been collected to date. A comprehensive analysis occurs twice yearly. Partners can request individualized reports by specified parameters.
- **Wellness Portal**. This is a web-based data collection tool developed in conjunction with Stony Brook University. It utilizes a pre and post-survey to measure the effectiveness of various chronic disease management programs and interventions, either evidence-based or non-evidence-based, offered by hospitals, community-based organizations, county health departments, and other appropriate providers. The programs/interventions must meet at least twice and cannot be support groups. The portal is completely de-identified by provider and program, and data is transferred to the LIHC for analysis. Customized reports are produced for portal users. The results are useful in determining the efficacy of an intervention and further resource allocation. Only a handful of LIHC partners have utilized the portal, limiting the LIHC's ability to provide a region-wide snapshot of the health of Long Islanders as gleaned from results of these various programs and interventions. Barriers to use include time-consuming process to enter data; competing data requirements with some evidence-based programs; reluctance on part of participants to initially complete surveys. The intent of the Wellness Survey is to offer the LIHC partners a universal metric tool for reference for a variety of reporting requirements – grant, state, etc. But lack of participation has hindered that goal.
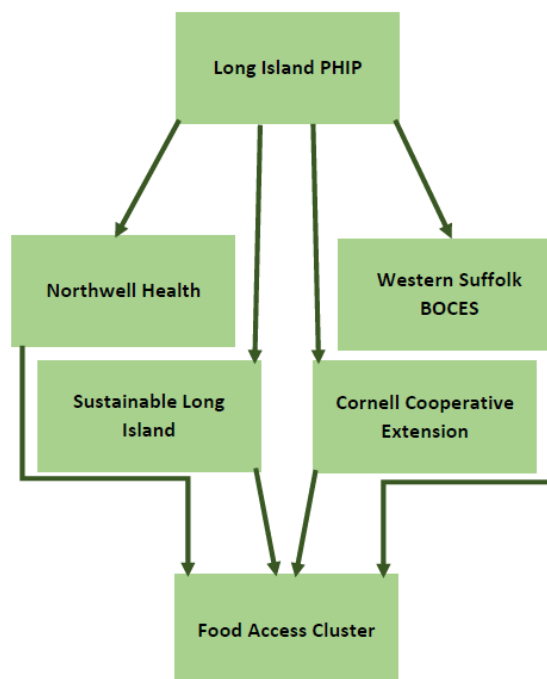
ACHIEVING OUTCOME DATA

Finding an easy way to collect meaningful data from among diverse partners has been and continues to be a challenge for all collaboratives working under the collective impact model. In the absence of agreed upon shared universal metrics, data culled from among the various interventions and programs offered by LIHC partners is a viable solution. Therefore, working under the collective impact model, we propose that partner data should flow to the LIHC where it can be synthesized and analyzed into useful reports.

MOVING FORWARD

The Collective Impact Think Tank event led to the re-organization and re-naming of LIHC's working groups. The **Food Access Cluster**, comprised of partners

Core Cluster Formation

Long Island PHIP

Northwell Health

Western Suffolk BOCES

Sustainable Long Island

Cornell Cooperative Extension

Food Access Cluster

The backbone organization will be responsible for administrative tasks (e.g. scheduling meetings, distributing agendas, taking meeting minutes, creating data reports, etc.) in supporting new work groups – now called "clusters".

Member organizations will continue to work on their own projects; however, they will be more aware of similar or complementary work being done by other members. We expect natural partnerships to emerge with the intent of closing gaps in service or enhancing data being collected.

Clusters would form organically through organizational programing in specific social determinants of health. The ultimate goal of these clusters is to meet Prevention Agenda objectives.

focused on combatting chronic disease through the strategy of improved nutrition and behavior change related to nutrition, formed organically during the Collective Impact Think Tank.

All working groups are now known as **Core Clusters.** Clusters are defined loosely around the social determinants of health. Other core clusters may include: **Physical Activity Cluster, Health Access Cluster.**

The Long Island PHIP will support this new structure of aligning the goals of the partners, many of whom come to the table already engaged in related grant activities. For example, members within the Food Access Cluster each possess an expert understanding of nutrition programs and food access activities occurring on Long Island. The participants of this first Food Access Cluster include the grant partners associated with the Eat Smart NY and Creating Healthy Schools and Communities programs, as well as the nutritionist from Northwell Health's Cohen Children's Medical Center.

Further, a Data Advisory Group will provide guidance to the collaborative staff and each cluster, as projects and data needs emerge. Similarly, a Public Education/Outreach Advisory Group will provide marketing/communications guidance to the collaborative and each cluster, as projects emerge.

Common Agenda
• Keeps all parties moving towards the same goal

Common Progress Measures
• Measures that get to the TRUE outcome

Mutually Reinforcing Activities
• Each expertise is leveraged as part of the overall

Communications
• This allows a culture of collaboration

Backbone Organization
• Takes on the role of managing collaboration

WHAT IS COLLECTIVE IMPACT

Collective Impact is a structured approach to solving social and human service needs. It draws upon the unique expertise of multiple organizations that commit to work together to achieve shared goals and objectives. A backbone organization, the LIHC, manages the collective efforts of participating organizations by way of administrative support, data collection and analysis, and other resources as reasonable and necessary.

The Long Island PHIP, as a state-funded grant initiative, is directed by the goals and objectives set forth by the New York State Prevention Agenda (See appendix). The Community Health Needs Assessment (CHNA) overseen by the Long Island PHIP on behalf of the region revealed that chronic diseases, especially those related to obesity remain the most pressing healthcare issue in the region. This need is accompanied by a commitment to address the mental health/substance abuse issues, which remain prevalent in the region, through prevention and wellness activities. Collaborative members agreed that interventions and programs emphasizing nutrition and physical activity are the two best approaches to tackling pervasive chronic diseases.   A CHNA assessment was conducted in 2013 and then again in 2016 with chronic disease rising to the top both times. The qualitative and quantitative data from the CHNA directed the selection of:

PRIORITY: PREVENT CHRONIC DISEASE (FROM THE PREVENTION AGENDA)

Ensuing discussion among collaborative participants led to the selection of these two focus areas under that priority:

- **Reduce obesity in children and adults**
- **Increase access to high quality chronic disease preventive care and management in both clinical and community settings**

Each focus area outlines goals. The obesity focus area lists four goals from which collaborative members can choose to concentrate their efforts. The chronic disease management focus area lists two goals.

Each goal is aligned with a specific and measureable objective(s). This is the endpoint, or change in health outcome, that the Long Island PHIP and its participants are collaboratively working toward. Through a variety of interventions, our collective efforts occurring community by community, contribute to the whole, unified effort to achieve the state's Prevention Agenda objectives.

COMMON AGENDA

Hence, our Shared Agenda, under the collective impact model, is:

- **Prevent Chronic Disease so that Long Islanders become well and/or stay well.**

COMMON PROGRESS MEASURES

These measures arise from the multitude of interventions and programs offered by collaborative members. Collaborative members were asked to complete a Data Collection Template during the Collective Impact Think Tank so that the Long Island PHIP would know what data is currently being collected and by whom. This informs the data analyses and customized reports that the LIHC staff can provide and further informs the ability for the region and its collective partners to arrive at health outcome data.

MUTUALLY REINFORCING ACTIVITIES

Collaborative members offer diverse programs and interventions. Some are evidence-based; some are activities occurring under the guise of other grants; some are original and innovative. However, as unique as the interventions are, they are similar in their goal to reduce chronic diseases. The activities reinforce one another and collectively move the region toward improved health outcomes.

COMMUNICATION

Perhaps the most important aspect of collective impact is communication. Without the sharing of data, information, and activities, we cannot work collaboratively to achieve our goal(s) and ultimately the state's Prevention Agenda objective(s). The Long Island PHIP is information central. As the backbone organization, it collects and organizes information and shares with all members and also provides communications/marketing support for Long Island PHIP's collective efforts and for the efforts of Cluster Groups.

BACKBONE ORGANIZATION

The Long Island Health Collaborative staff comprise the backbone for the Long Island PHIP.

LOGIC PROCESS – THE WAY FORWARD

After reviewing all data collection sheets, comments written on the flip charts, processing verbal comments and conversations, and responses to the post-event survey, the following thought process emerged:

Ultimate Collective Impact	—>	Reduce chronic disease incidence
Diverse Partners	—>	Each assess area of interest/specialty and match to community need and each partner's capabilities
Social Determinants of Health Core Groups	—>	Form naturally out of self-assessment *Example: Food access/nutrition, built environment (includes transit), economic stability/poverty*
Align with New York State Prevention Agenda Goals	—>	Each group chooses 1 goal from among Focus Areas 1 and 3, (as noted in the state's Prevention Agenda – see Appendix) then chooses one measurable objective from the Prevention Agenda as the health outcome for which the group seeks to impact.
Data Pool	—>	Each member from the core group all the while continues collecting its data (for grant needs, etc.). Group decides what data set will best inform their efforts and shares with LIHC for analysis.
Data Verification/Amplification	—>	LIHC continues working on population level data sets to assist groups in overlaying these results (by zip, by disease, by demographics, via mapping, etc.) to spot changes/trends that inform impact. LIHC could commit to producing defined set of reports on quarterly basis, for example.
Strategies/Interventions	—>	Each group studies suggestions offered on Prevention Agenda site. Choose from among these or tailor their own.
Assistive Tools (LIHC) *Special projects continue concurrently (i.e. library asset mapping project) and LIHC staff supports and initiates new ones*	—>	– Peer-reviewed research articles, trend reports, and studies organized by social determinant or health topic provided to Core Clusters to help inform their efforts. – One summary from CITT, including key themes – Ongoing marketing/outreach assistance for clusters' work (videos, releases, social media, interim reports, PowerPoints, fact sheets, etc.) – Ongoing planning/administrative assistance for clusters' meetings (phone, in person, web) – establish Google Drive folder for each
Collaborative-wide Activities	—>	Current LIHC programs – clusters can use these programs to support their work – even use as interventions.

CONCLUSION

The Collective Impact Think Tank offered an opportunity for the Long Island Health Collaborative staff and the many diverse participants of the collaborative to reassess and reset priorities and goals. This collective exercise is the first step in re-focusing our energies and activities in the direction that best meets the needs of all collaborative members, and ultimately, the health needs of all Long Islanders who are struggling with chronic illnesses.

TOWARD THAT OVERARCHING GOAL, THE LONG ISLAND HEALTH COLLABORATIVE REAFFIRMS ITS COMMITMENT TO:

- **convening diverse partners;**
- **engaging in primary and secondary data collection and analyses;**
- **conducting consumer and provider-facing public information/awareness campaigns;**
- **supporting adoption of policies related to healthier living;**
- **promoting chronic disease self-care;**
- **providing a web-based walking initiative for use by the public and organizations seeking a platform in which to engage patients/clients/employees in a walking program.**

LONG ISLAND PHIP/LONG ISLAND HEALTH COLLABORATIVE

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Priority	Focus Area	Goal	Objective - By December 31, 2017
	Reduce illness, disability and death related to tobacco use and secondhand smoke exposure	• Prevent initiation of tobacco use by New York youth and young adults, especially among low socioeconomic status (SES) populations	Decrease the prevalence of any tobacco use (cigarettes, cigars, smokeless tobacco) by high school age students by 30% from 21.2% in 2010 to 15.0%. (Data source: NY Youth Tobacco Survey) (Data Availability: state)
		• Promote tobacco use cessation, especially among low SES populations and those with poor mental health	Decrease the prevalence of cigarette smoking by adults by 18% from 18.4% in 2011 to 15.0%. (Data source: NYS BRFSS; Data Availability: state; county), HP 2020 (TU-1.1) target: 12% **Reduce disparity:** • Decrease the prevalence of cigarette smoking among adults with income less than $25,000 by 30% from 28.5% (2011) to 20%. (Data Source: NYS BRFSS Data Availability: state) Increase the utilization of smoking cessation benefits among smokers who are enrolled in Medicaid Managed Care by 141% from 17% (2011) to 41%. (Data source: Medicaid) (Data Availability: state)
		• Eliminate exposure to secondhand smoke.	See the "Prevent Chronic Diseases Action Plan", Page 18
	Increase access to high quality chronic disease preventive care and management in both clinical and community settings	• Increase screening rates for cardiovascular disease, diabetes and breast/cervical/colorectal cancer, especially among disparate populations	Increase the percentage of adults (50-75 years) who receive a colorectal cancer screening based on the most recent guidelines (blood stool test in the past year or a sigmoidoscopy in the past 5 years and a blood stool test in the past 3 years or a colonoscopy in the past 10 years) by 5% from 68.0% (2010) to 71.4%. (Data Source: NYS BRFSS) (Data Availability: state, county), HP 2020 (C-16) target: 70.5% (all adults) **Reduce disparity:** • Increase the percentage of adults (50-75 years) with an income of less than $25,000 who receive a colorectal cancer screening based on the most recent guidelines by 10% from 59.4% (2010) to 65.4%. (Data Source: NYS BRFSS) (Data Availability: state)

Priority	Focus Area	Goal	Objective - By December 31, 2017
		• Promote use of evidence-based care to manage chronic diseases	Reduce the asthma emergency department visit rate by 10% from 83.4 per 10,000 residents (2007-09) to 75.1 per 10,000 residents all ages (Data Source: SPARCS) (Data Availability: state, county, zip code) **Reduce disparity:** • Reduce the asthma emergency department visit rate by 28% from 218.3 per 10,000 (2007-2009) to 196.5 per 10,000 for residents ages 0-4 years (Data Source: SPARCS) (Data Availability: state, county, zip code) Increase the percentage of health plan members, ages 18 to 85 years, with hypertension who have **controlled their blood pressure** (below 140/90) by 10% from 63% (2011) to 69.3% for residents enrolled in commercial managed care health insurance, and by 7% from 67% (2011) to 72% for residents enrolled in Medicaid Managed Care (Data Source: NYS QARR; Data Availability: state and by plan) **Reduce disparity:** • Increase the percentage of health plan members, ages 18 to 85 years, with hypertension who have controlled their blood pressure (below 140/90) by 15% among black adults enrolled in Medicaid Managed Care from 58% (2011) to 66.7%. (Data Source: NYS QARR) (Data Availability: state) Increase the percentage of adult health plan members with diabetes whose **blood glucose is in good control** (hemoglobin A1C less than 8%) by 7% from 58% (2011) to 62% for residents enrolled in Medicaid Managed Care; and by 10% from 55% (2011) to 60.5% for residents enrolled in commercial managed care insurance (Data Source: NYS QARR; Data Availability: state and by plan)

Priority	Focus Area	Goal	Objective - By December 31, 2017
			Reduce disparity:
			• Increase the percentage of adult health plan members with diabetes whose blood glucose is in good control (hemoglobin A1C less than 8%) by 10% from 56% (2011) to 62% for black adults enrolled in Medicaid Managed Care (Data Source: NYS QARR) (Data Availability: state)
			Reduce the rate of hospitalizations for short-term complications of diabetes by 10% from 3.40 per 10,000 (2007-09) to 3.06 per 10,000 for residents ages 6-17 years and from 5.40 per 10,000 (2007-09) to 4.86 per 10,000 for residents ages 18+ years (Data Source: SPARCS; Data availability, state, county)
			Reduce the age-adjusted hospitalization rate for heart attack by 10% from 15.5 per 10,000 residents (2010) to 14.0 per 10,000 residents all ages (Data Source: SPARCS; Data Availability: state, county)
		• Promote culturally relevant chronic disease self-management education	See the "Prevent Chronic Diseases Action Plan", Page 26