Methodology

Introduction

For the 2019 assessment, the Ozarks Health Commission (OHC) built on the methodology developed for the 2016 assessment. The approach combines secondary data, hospital data, and community feedback on several levels to guide the prioritization process. The core data in the assessment is secondary community health indicators, which are available across various publicly available datasets. In addition to the secondary data, the hospital systems pulled data from their emergency departments and clinical quality measures to provide a more in-depth and timely examination of the Assessed Health Issues (AHI). The OHC then gathered community input and feedback by conducting a survey and hosting community key partner meetings to provide additional perspectives on the AHI.

Throughout the primary and secondary data collection, the OHC steering committee provided direction, feedback, and guidance; detailed research and analysis efforts took place within several subcommittees. The subcommittees completed work on secondary indicators, survey development, hospital data, and health issues and prioritization. The majority of the work completed by the subcommittees happened concurrently, between October 2017 and December 2018. The following sections detail these processes and findings of the data components of the assessment.

Secondary Data Process

A subcommittee on community health secondary data indicators was formed to identify indicators, collect and compile relevant data, and conduct a review of the findings. The subcommittee was comprised of public health partners from the steering committee. The subcommittee began their work in the Fall of 2017 and completed work in June 2018. The subcommittee focused on the primary collection point of data that was used for the first assessment, which was Community Commons, through the Community Health Needs Assessment portion of the website. A Community Health Needs Assessment report was run for each Community and the OHC Region in October 2017 and May 2018. Additional data was also collected from the 2016 Missouri Student Survey County Reports, 2016 Arkansas Prevention Needs Assessment Survey, and the Department of Health and Senior Services – MOPHIMS, Cancer Incidence MICA.

As the secondary data was collected and compiled, it was aggregated into the OHC Communities and placed into comparison charts to allow for a side-by-side examination of the data between Communities, the OHC Region, and the nation. The subcommittee first reviewed the key indicators that were identified through the 2016 assessment. Then the subcommittee reviewed all other indicators that performed more poorly than the nation and examined the relevance and significance to determine if any key indicators should be added. The indicators were then grouped into related indicators. These produced the same set of AHI and Common Threads as were identified in 2016. After the data was

reviewed, the subcommittee provided their findings to the steering committee. The following are the key findings of the secondary community health indicators.

Identifying Health Issues

A subcommittee was formed to review, update, and finalize the process of identifying and prioritizing the health issues for the OHC Region and Communities. This subcommittee included representation from public health; they began meeting in January 2018 and concluded their work in April 2018. The secondary data key findings revealed that the OHC Region is under-performing in 37 indicators.

During the 2016 assessment, the under-performing indicators were examined and placed into similar groupings to create health issues. This process identified seven groupings that the OHC Region considered AHI, and two additional groups for social determinants of health and access to care. Then the subcommittee identified associated indicators and placed them into their group. For example, high blood pressure and cholesterol, as well as other health issues related to the cardiovascular system, were collapsed into "cardiovascular disease". If relevant, an indicator was used in multiple groupings.

The seven AHI were: Cancer, Cardiovascular Disease, Lung Disease, Oral Health, Mental Health, Maternal and Child Health, and Diabetes. During this process, the subcommittee decided to remove the Maternal and Child Health grouping and place this category under population of interest.

The subcommittee concluded the process by reviewing the AHI scoring process. The scoring matrix includes key data points from secondary data, hospital data, and community perspective, providing a more thorough examination of the AHI. The following sections outline the AHI and social determinants of health and the scoring process.

AHI Defined

Cancer

- Incidence-lung, colon & rectum, and cervical cancer
- Mortality-cancer
- Tobacco use
- Cancer screenings: mammograms, cervical, sigmoidoscopy or colonoscopy

Cardiovascular Disease

- Heart disease and stroke mortality
- Elevated blood pressure
- Elevated cholesterol levels
- Heart disease morbidity
- Obesity and overweight

- Physical inactivity
- Fruit/veggie consumption
- Tobacco use (adult and youth)

Diabetes

- Diabetes prevalence
- Screening - A1c test
- Obesity and overweight
- Fruit/vegetable consumption
- Physical inactivity

Lung Disease

- Mortality – lung disease
- Asthma prevalence
- Tobacco use (adult and youth)
- Physical inactivity

Mental Health

- Suicide
- Depression
- Access to mental health providers
- Mortality – drug poisoning

Oral Health

- Dental care utilization
- Poor dental health
- Access to dentists

Social Determinants of Health

- Families earning over $75,000
- Per capital income
- Poverty – population below 100% and 200% FPL
- Children eligible for free/reduced price lunch
- Percent population age 25 with associate degree or higher
- Percent population age 25 and older without a high school diploma

Access to Care

- Uninsured adults
- Preventable hospital events
- Access to primary care
- Population living in a health professional shortage area
- Lack of a consistent source of primary care
- Access to dentists
- Dental care utilization
- Access to mental health providers

Hospital Data

One of the unique aspects of the Ozarks Health Commission (OHC) Regional Health Assessment (RHA) is the collection of data from partnering hospitals. Hospital data provides a more real-time evaluation of community health needs than secondary data, which lags three to five years. Additionally, it allows the OHC to study specific health needs in relation to the AHI in each community. This approach assists in determining priority health issues and developing strategic Community Health Implementation Plans (CHIPs) that align with the strengths of healthcare, public health, and community-based agencies.

To supplement population health data with more timely and in-depth information concerning the OHC Region populations, two types of primary hospital information were utilized: Emergency Department (ED) and Merit-Based Incentive Payment System (MIPS) data. This section of the report details demographic and payer information of all ED patients, as well as those presenting with health issues relating to the AHI.

The 29-county OHC Region is divided into six Communities, which each contain one or more hospitals. The table below outlines the counties and hospitals with an Emergency Department (ED) in each Community.

Community	**Counties**	**Hospital ED**
Branson	Boone, Carroll, Stone, Taney	CoxHealth Branson, Mercy Berryville
Joplin	Barton, Cherokee, Crawford, Jasper, Labette, McDonald, Newton, Ottawa, Vernon	Freeman Health System Joplin, Freeman Health System Neosho, Mercy Columbus, Mercy Carthage, Mercy Joplin
Lebanon	Camden, Dallas, Laclede, Pulaski, Texas, Wright	Mercy Lebanon
Monett	Barry, Lawrence	CoxHealth Monett, Mercy Aurora, Mercy Cassville

Mountain View	Baxter, Douglas, Howell, Ozark, Shannon	Mercy St. Francis
Springfield	Christian, Greene, Webster	CoxHealth South, CoxHealth North, Mercy Springfield

The RHA included the collection and analysis of hospital data which was aggregated. Findings are reported in the data and findings portion of the report. A subcommittee of the OHC, the primary data subcommittee, worked to identify and agree upon hospital datasets to include in the assessment. The primary data subcommittee—comprised of hospital representatives from all three partnering health systems and public health representatives—reviewed indicators and collection methods used in the 2016 RHA. To supplement population health data with more timely and in-depth information concerning the OHC Region populations, two types of primary hospital information were utilized: Emergency Department (ED) and Merit-Based Incentive Payment System (MIPS) data.

Emergency Department Data

The ED methodology is similar to that of the 2016 RHA, focusing on all visits by patients through emergency departments. This approach provides the opportunity to assess potential health disparities across patient groups, as well as assess the prevalence of mental illness within emergency departments.

The following ED visit data was collected for calendar year 2017:

- ED Only vs ED Admitted
- Top 20 Patient Home Zip Codes
- Emergency Severity Index
- Principal Diagnosis Group
- Age Groups
- Principal Diagnosis Group, Age 0-17
- Principal Diagnosis Group, Age 18-64
- Principal Diagnosis Group, Age 65+
- Payer Group
- Payer Group, by Principal Diagnosis Group
- Race
- Race Groups (Top 5) by Principal Diagnosis
- ED Visits with a Behavioral Health (BH) Principal Diagnosis by Top 20 Coded Diagnosis *(Repeat above for those with BH Principal Diagnosis)*
- ED Visits with a BH Secondary Diagnosis (non BH Principal) by Principal Diagnosis Group *(Repeat above for those with BH Secondary Diagnosis)*

The first three digits of ICD-10 diagnosis groups were used to ensure consistent data collection across health systems. Behavioral diagnoses were specified as ICD-10 Codes for Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99). In order to aid in efficient aggregation of ED data, each health system completed a standardized report template and submitted this to the SGCHD.

Clinical Data

The subcommittee determined that the addition of clinical data enhanced the assessment of health care utilization and established a baseline for quality improvement activities. After considering several nationally reported measures, Merit-Based Incentive Payment System (MIPS) data was selected.

Specifically, the following MIPS clinical quality indicators were selected for their alignment with the AHI identified by the secondary data subcommittee to be reported for calendar year 2017 by each health system:

• Cancer	Colorectal Cancer Screening (CMS 124)
• Cardiovascular Disease	Controlling High Blood Pressure (CMS 165)
• Diabetes	Diabetes HbA1c Poor Control (CMS 122)
• Lung Disease	Tobacco Use Screening and Cessation Intervention (CMS 138)
• Mental Health	Screening for Depression and Follow-Up Plan (CMS 2)

Aggregation & Analysis

SGCHD combined the health systems' ED data sets, and separately aggregated MIPS data sets. Data is reported for the entire OHC Region, as well for OHC Communities where more than one health system operates. In Communities where only one facility or one system is present, the information is reported alone. Community information is presented as a percent or rate, not as whole numbers or visit counts.

The primary data subcommittee analyzed the aggregated data for an improved understanding of population level health disparities, as well as the severity and impact of Assessed Health Issues on the Region's EDs, as well as the quality emphasis of provider clinics. This data, along with community input, is combined with other data sources to help to determine health priority issues.

Local Input Survey

In order to engage community residents in the community health needs assessment process, OHC partners agreed in May 2018 to administer a survey across the entire Region. A subcommittee drafted the survey, which the steering committee reviewed to aid in a better understanding of the intent of the questions. For example, it was important to gain feedback on assessed health issues. So, respondents were asked to rate the importance, on a scale of one to four, of the following health issues addressed in each community: oral health, lung disease, mental illness, cancer, smoking, maternal and child health, and finally the opioid epidemic. The data received from that question was used in the prioritization process.

Over a two-month period, the survey was refined with a focus on obtaining community feedback to address the assessed health issues identified through public health and hospital data. Basic demographic information collected included county, age, gender, race/ethnicity, educational attainment, employment status, household income, the presence of children in the home, housing status,

and health rating and diagnosis information. To assure the survey was developed effectively, unbiased, and provided in both English and Spanish, the subcommittee received guidance and translation services from Drury University. The survey and its findings can be found in the data and findings portion of the report.

Survey Administration

Between June and August 2018, Survey Monkey was used to collect and compile the majority of survey data, and paper surveys were made available to those who faced electronic barriers to completing it online. The survey was developed not only to find geographical data, but to find data related to the respondent's health care needs and what the barriers to those needs might be. Individual partner organizations were asked to promote the survey via email, networking, social media, and point of service within facilities. Incentives were not offered to participants at any point of survey collection. Preliminary results were collected at the beginning of August, with final results analyzed later that month.

Health Indicator Scoring – Prioritization

To determine the process for prioritizing AHI, the subcommittee began by reviewing the process that was developed for the 2016 assessment. For that assessment, information from Kaiser Permanente and the National Association of County and City Health Officials (NACCHO) were used as guides. The subcommittee identified Hanlon's Method as the best fit with the assessment process because it is ideal when health issues are considered against multiple criteria, but recognized that modifications were needed to better fit the process, data, and Communities within the assessment. The resulting "Prioritization Matrix" was created to score the identified AHI.

Prioritization Matrix Components

The Prioritization Matrix consists of two scoring themes: data and input from the community. The data used includes morbidity and mortality data, morbidity and mortality trend data, morbidity and mortality comparison to national rates, hospital emergency department data, and clinical quality measure data. Community input includes broad-based community input on the AHI and community stakeholder input on the community feasibility and readiness to change the issue. With each factor that is mentioned, a score based on the data/feedback was given a score of 1-4, with the higher scores representing information that suggests the need for prioritization of the issue.

The AHI receives a rank between one and four, with a rank of one being the best performing and four being the worst performing in comparison to the national benchmarks. A regional MIPS measure receives the following rank if it falls in that rank's corresponding decile:

Regional MIPS Measure Rank	Benchmark Decile
4	4, 3, <3
3	5, 6

2	7, 8
1	9, 10

As indicated in the table above, the MIPS measures for each of the AHI received the highest or worse score in comparison to the national benchmarks.

Morbidity

Morbidity (also commonly referred to as prevalence) evaluates how common the health issue is in a population. Typically, it is represented as a percentage of the population with the health issue. For health issues without available prevalence data, the incidence rate was used. There are multiple indicators that are within the defined health issues. When multiple indicators define the health issue, each indicator is scored and the average of all indicator scores create the overall morbidity score. The morbidity data is based on the NACCHO health assessment information.[1] Incidence data thresholds were created by the subcommittee, which based the top category on an incidence rate that would create a prevalence of five percent within a ten-year period.

Score	Prevalence	Incidence (per 100,000)
4	≥25%	> 500
3	10% - 24.5%	250 - 499
2	1% - 9.9%	100 - 249
1	<1%	< 100

Mortality

Death rates (mortality) are used to evaluate long-term impact and severity of a health issue to a community. As with prevalence, multiple indicators may be used to represent the health issue. The score was based on taking the Region's highest mortality rate (heart disease 211 per 100,000) and creating quartiles.

Score	Severity/Seriousness
4	*>158.25*
3	*105.5 – 158.25*
2	*52.75 – 105.5*
1	*<52.75*

[1] https://www.naccho.org/programs/public-health-infrastructure

Morbidity and Mortality Trend

Examining the trend data for morbidity and mortality provides additional information on whether a health issue continues to be an issue in the communities and should be a priority. Percent difference [(community rate 2015 – community rate 2018)/community rate 2018] is used to understand how the community rates have changed from 2015 to 2018. The 2015 data was recalculated to represent the current OHC Region footprint.

Score	Percent Difference
4	>10% Increase
3	<10% increase
2	<10% decrease
1	>10% decrease

Morbidity and Mortality Comparison to National Rate

In addition to knowing the morbidity and mortality rate in a community, further comparing the rate to the nation provides additional information on whether a health issue should be prioritized. Percent difference [(community rate – national rate)/national rate] is used to understand how the community rates differ from the national rates. Applying percent difference instead of simply relying on the difference between community and national rates provides more consistent and accurate comparisons across categories. The subcommittee developed the four thresholds and used a consensus approach to develop the thresholds.

Score	Percent Difference
4	>25% higher than national rates
3	11% - 24% higher than national rates
2	1% - 10% higher than national rates
1	≤ national rates

Hospital Data: Emergency Department

Secondary data provides a robust look at health indicators and health issues in a community, but there are certain limitations to exclusively using secondary data to determine health priorities. Most notably, secondary data typically lags three to five years, raising concerns whether the data is too dated to fully represent the health issue. Layered primary data from hospital systems helps to provide greater confidence in the process and final conclusions/health priorities. The primary data used in this process comes from individual hospital Emergency Departments and Clinics from throughout the Region. Visits to the Emergency Department and Clinics were classified by the Principal Diagnosis Group (using ICD-10 coding). The visits based on Principal Diagnosis Group were tabulated for each Community. The Principal Diagnosis Groups were then associated with Health Issues (e.g. Diseases of the Respiratory

System and Lung Disease). The primary data score was then based on the percent of Emergency Department visits and Clinical visits associated with identified AHI.

Score	Percent of Visits Associated with Health Issues
4	>25% of visits
3	11% - 24% of visits
2	1% - 10% of visits
1	< 1% of visits

Hospital Data: Clinical Quality

Metrics from the Merit-Based Incentive Payment System (MIPS) were selected to enhance the assessment of healthcare utilization and establish a baseline for quality improvement activities across the Region. The table below outlines the selected MIPS clinical quality indicators, their alignment with the AHI, and their descriptions. To align with the ED data analysis, oral health was not included in the selection and evaluation of MIPS measures.

Score	Measure	Measure Description
Cancer	Colorectal Cancer Screening (CMS 130)	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer
Diabetes	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (CMS 122)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period
Mental Disorders	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan (CMS 2)	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen
Lung Disease	Preventative Care & Screening: Tobacco Use: Screening and Cessation Intervention (CMS 138)	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user
Cardiovascular Disease	Controlling Hypertension (CMS 165)	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period

Each OHC partnering health system provided the selected MIPS metrics for their service area within the Region. The metrics were aggregated to create scores for the Region and then ranked according to their performance in comparison to national benchmarks. The table below outlines the following:

- AHI
- MIPS Quality Measure corresponding to selected AHI
- MIPS score for the Region
- MIPS national average
- Decile range and decile in which the Region MIPS score falls
- Benchmark range, or the score for the tenth decile for its respective measure
- Rank of the AHI

AHI	MIPS Quality Measure	Region (%)	MIPS Average (%)	Decile Range	Decile	Benchmark (BM) Range	Rank
Cancer	Colorectal Cancer Screening	46.55	60.90	46.82 - 51.65	<3	>= 80.95	4
Cardiovascular Disease	Controlling Hypertension	63.33	66.50	60.41 - 64.27	4	>= 79.74	4
Diabetes	Hemoglobin A1c Poor Control (>9%)	28.19	22.00	33.33 - 23.54	3	<=3.33	4
Lung Disease	Tobacco Use: Screening and Cessation Intervention	70.96	86.20	82.06 - 86.04	<3	>= 99.32	4
Mental/ Behavioral Health	Screening for Clinical Depression and Follow-up Plan	29.94	65.30	29.28 - 65.00	4	100.00	4

Local Input Data

The survey had a total of 2,525 responses. Of these responses, 2,478 (98%) were in English and 44 (2%) were in Spanish. Respondents were asked to indicate the county where they receive the majority of their healthcare. Three counties: Jasper County, MO (38%); Greene County, MO (26%); and Newton County, MO (16%) led the way with a combined 81% of the overall total. Note that this is not necessarily indicative of which county these individuals actually reside in, as both the Springfield and Joplin areas are home to large regional healthcare providers.

The following is a brief review of survey findings. Of the respondents, 83% were female; 58% were 46 years of age or older; 91% identified themselves as white, 4% as Hispanic or Latino; 39% reported having children under the age of 18; 66% were married or in a domestic partnership; and, overall, the group was highly educated with 51% having a Bachelor's degree or higher compared to 15% with a high

school diploma or less. Only 5% of those taking the survey reported themselves as unemployed and self-pay/uninsured. Home ownership was reported by 76% of those surveyed.

- Mental illness (75%), maternal and child health (64%), and opioid abuse (63%) were the top three health issues rated as "really important" that survey participants felt needed to be addressed in their community.
- When asked to list their three most important factors for a "Healthy Community", respondents most often selected access to health care (49%), low crime/safe neighborhoods (47%), and good jobs and healthy economy (47%). Other factors scoring high included good schools (32%) and healthy behaviors and lifestyles (29%).
- The large majority (88%) of respondents rated their own health as either healthy or very healthy. Only 1% of those surveyed rated themselves as very unhealthy.
- The primary barrier preventing respondents from using health services was cost (43%), with insurance doesn't cover service (21%) and lack of providers (10%) also frequently cited.
- A total of 4% of respondents reported living without stable housing either currently or at some point within the past two years.
- The majority of those surveyed (77%) denied any exposure to secondhand smoke. When exposure was reported, 15% of the time it was attributed to exposure from restaurants and other businesses. Secondhand smoke exposure at home was reported by only 9% of those surveyed.

Feasibility to Change the Issue

Feasibility to change evaluates the complexity of the issue, the control the community has over the issue, and the understanding of a path for implementation. Issues with a clear, evidence-based approach and those which can be solved by addressing a single issue are viewed as more feasible to change, whereas ones that are multi-faceted or with no clear approach to change are viewed less feasible. To illustrate, mental health is a multi-faceted health issue with no clearly defined path to make significant improvements in a limited time frame. The subcommittee based the categories on information found within the NACCHO Guide to Prioritization Techniques[2] and used community experience of subcommittee members to determine definitions and thresholds for the categories. Contrary to the first two ranking criteria, "Feasibility to Change the Issue" and "Community Readiness

[2] https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf

to Change" are a more broad and inclusive examination of the health issue in the community, rather than focusing on a single indicator.

Score	Feasibility – Complexity of the Issue
4	Single health issue that can be improved in 2-3 years
3	Multi-faceted health issue that can be improved in 2-3 years
2	Single health issue that cannot be improved in 2-3 years
1	Multi-faceted health issue that cannot be improved in 2-3 years

Issues that can be addressed at a local level are viewed to be more feasible to change, whereas issues that are not controlled by the community are viewed as less feasible to change. To further illustrate, access to care is largely impacted by whether or not a community has expanded Medicaid, which is not feasible for an individual community to change.

Score	Feasibility – Level of Control at Local Level
4	Local control to create policy or system change
3	Some local control to create policy or system change
2	Little local control to create policy or system change
1	Unknown level of control

A community that has developed a clear path based off of their understanding of the issue is viewed to be more likely to change, whereas a community with no understanding or path are less likely to change.

Score	Feasibility – Clear Path for Implementation
4	Clear path of what is needed and is currently in place or development
3	Clear path of what is needed, but no current efforts in development or early in development
2	Moderate understanding of what is needed, but no efforts are in development
1	Unknown or no understanding about what efforts are needed

Community Readiness to Change

Community readiness to change evaluates both the community and organizations within the community's readiness to impact the issue. Organizations that have efforts or funding already in place to address an issue are more ready to impact change. Communities that have both key organizations serving as a backbone for a health issue and community collaboration that is moving in a parallel and coordinated fashion are more closely following the Collective Impact Model[3], which provides an effective approach to advance progress around community issues. This approach was developed by the steering committee, which based the standard on the Collective Impact Model and used a consensus approach to determine the breakpoints for scoring.

Score	Readiness – Current Organizational Leadership
4	Current community organizational leading with the capacity and experience in addressing the issue
3	Current community organization leading but with limited capacity and experience in addressing the issue
2	No current community organization leading the effort
1	Organization leadership unknown

A community with collaborative efforts already underway is more likely to adopt health priorities and impact change. Priority was placed on having community collaboration already in place due to the fact that this component of change can take longer and be more challenging to put into place than an organization's focus.

Score	Readiness – Coordinated Community Efforts
4	Formal community partnership in place with evidence of success
3	Formal community partnership in place but with limited success
2	Informal community partnership or no community coordinated efforts
1	Community partnership unknown

These criteria provide the scores for each health issue, which were then used by community stakeholders to build consensus and select priority health issues. For the factors related to feasibility and readiness to change, Communities used a consistent process to collect input from partners and build consensus. The subsequent section outlines this process.

Process to Build Consensus of the Feasibility and Readiness for Assessed Health Issues and the Selection of Priority Health Issues

There are two main components of the prioritization process: a quantitative element that includes secondary data sources, hospital data sources and a local input survey, and a qualitative element that includes community perception on the feasibility and readiness for community change. Within each of these elements in the prioritization process, multiple factors are included and are used to create scores based on the data and perceptions of need. While the quantitative elements of this process are collected through the compilation and analysis of data, the qualitative elements needed to be collected through discussion and gathered input from the community. By engaging with a group of community stakeholders, the objective process for determining priorities includes community perspective, which helps ensure that the best fit priorities are selected. The following process describes how the OHC collected input and perspective in various communities on feasibility and readiness to change, as well as building consensus for the health priorities.

Gathering & Informing the Stakeholders

Communities within the OHC Region used a variety of approaches to determine and assemble stakeholders. The most common approaches were to use an existing group of community members and/or leaders that are already meeting to focus on health, and to recruit a group of community members and/or leaders to meet. In either approach, a group of stakeholders were sought out, including members of various sectors and demographic groups. Groups typically consist of 10 to 25 individuals.

As the groups were convened, the first priority was to describe the purpose and assessment processes that have been used to identify the assessed health issues, and inform the stakeholders of the quantitative results that inform the prioritization process. These results focus on key indicators and their ranked score associated with each assessed health issue. The presentation of the results included both handouts and/or presentations describing these elements.

Facilitating Discussion around Feasibility and Readiness

A member of the OHC or close community partner facilitated discussion with the gathered stakeholders around the issues of feasibility and readiness with each of the assessed health issues. The following was the discussion guide and questions to prompt discussion.

There are five components that will be rated by the community stakeholders for each of the six assessed health issues identified within the OHC Region. Within Feasibility to Change there are three components to be rated: Complexity of the Issue, Level of Control and the Local Level, and a Clear Path for Implementation. Within Readiness to Change there are two components to be rated: Current Organizational Leadership and Coordinated Community Efforts. Each of the five components were described and then discussion around each component for each health issue will be discussed. The following descriptions from the process for prioritization matrix were used:

Complexity of the Issue: Feasibility to change evaluates the complexity of the issue, the control the community has over the issue, and the understanding of a path for implementation. Issues with a clear, evidence-based approach and those which can be solved by addressing a single issue are viewed as more feasible to change, whereas ones that are multi-faceted or with no clear approach to change are viewed less feasible. To illustrate, mental health is a multi-faceted health issue with no clearly defined path to make significant improvements in a limited time frame. The subcommittee based the categories on information found within the NACCHO Guide to Prioritization Techniques[3] and used community experience of subcommittee members to determine definitions and thresholds for the categories. Contradictory to the first two ranking criteria, “Feasibility to Change the Issue” and

[3] National Association of County & City Health Officials, http://archived.naccho.org/topics/infrastructure/CHAIP/upload/Final-Issue-Prioritization-Resource-Sheet.pdf

"Community Readiness to Change" are a more broad and inclusive examination of the health issue in the community, rather than focusing on a single indicator.

Level of Control at Local Level: Issues that can be addressed at a local level are viewed to be more feasible to change, whereas issues that are not controlled by the community are viewed as less feasible to change. To further illustrate, access to care is largely impacted by whether or not a community has expanded Medicaid, which is not feasible for an individual community to change.

Clear Path for Implementation: A community that has developed a clear path based off of their understanding of the issue is viewed to be more likely to change, whereas a community with no understanding or path is less likely to change.

Current Organizational Leadership: The community readiness to change evaluates both the community and organizations within the community's readiness to impact the issue. Organizations that have efforts or funding already in place to address an issue are more ready to impact change. Communities that have both key organizations serving as a backbone for a health issue and community collaboration that is moving in a parallel and coordinated fashion are more closely following the Collective Impact Model[4], which provides an effective approach to advance progress around community issues. This approach was developed by the steering committee, which based the standard on the Collective Impact Model and used a consensus approach to determine the breakpoints for scoring.

Coordinated Community Efforts: A community with collaborative efforts already underway is more likely to adopt health priorities and impact change. Priority was placed on having community collaboration already in place due to the fact that this component of change can take longer and be more challenging to put into place that an organization's focus.

Rating Feasibility and Readiness

As the facilitated discussion takes place around each health issue, community stakeholders individually rate the varying factors on the scale provided earlier in this section of the report. This rating was performed either as each individual component (e.g. complexity of health issue) was discussed, as each element was discussed (e.g. all components within feasibility), or at the end of the entire discussion for a health issue. To collect the ratings, communities could use a variety of methods including paper rating sheets or completion of an online survey, such as Survey Monkey or Kahoot. Additionally, Communities could receive this feedback from stakeholders either at the meeting or via online survey prior to the meeting. The individual ratings for each component were then compiled and averaged during the meeting. These averaged scores were then entered into the Prioritization Matrix and displayed for community stakeholders.

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[4] Collective Impact Forum, https://collectiveimpactforum.org/what-collective-impact

Building Consensus for Health Priorities

After the community stakeholders were shown the final scores for each health issue in the prioritization matrix, the facilitator(s) led a discussion to build consensus around the final health priorities. This final selection could occur either at the same meeting or at a follow up meeting. It also could have included the same group of stakeholders or a different group of stakeholders. For instance, in the Springfield Community, the discussion occurred with stakeholders who focused on implementation of strategies to address health issues. Final consensus and selection of health priorities was made by another group consisting of executive leadership from throughout the community.

These meetings created the draft health priorities for each Community within the Region. These priorities were then taken to the executive boards for all participating health systems and local public health agencies within the community for review and final approval.