

LEARNING COMMUNITIES:

Building Partnerships to Improve Community Health through Data Sharing

August 2019

 **MINNESOTA**

HEALTH CARE HOMES
MINNESOTA DEPARTMENT OF HEALTH

Report prepared by:
ACET, Inc.



INTRODUCTION

The Minnesota Department of Health (MDH), through the Health Care Homes (HCH) Program, helps support clinics across the state to improve patient outcomes.

The HCH Program is centered around three goals:

- 1.** Continue building a strong primary care foundation to ensure all Minnesotans have the opportunity to receive team-based, coordinated, patient-centered care;
- 2.** Increase care coordination and collaboration between primary care clinicians and community resources to support whole person care and facilitate the broader goals of improving population health and health equity; and
- 3.** Improve the quality, experience, and value of care.

The HCH Program has certified 389 clinics throughout the state of Minnesota, with additional facilities in Wisconsin, North Dakota, and Iowa serving more than 3.3 million Minnesotans.^(1,2) Certified HCH clinics are evaluated based on a set of performance measures collected for quality improvement as part of the Statewide Quality Reporting Measurement System (SQRMS). HCH clinics receive support through MDH, including an annual Learning Days conference, announcements of upcoming events, resources posted on the HCH YouTube playlist, the HCH Advisory Committee and work groups (e.g., financial sustainability; learning and technical assistance; partnerships and communications), bulletins and quarterly newsletters, and funding and support for an HCH Learning Collaborative.

¹ Minnesota Department of Health. (July 17, 2018). Certified Health Care Homes. Retrieved on August 14, 2018, from:

<http://www.health.state.mn.us/healthreform/homes/documents/hchcert.pdf>.

² Marie Maes-Voreis. (2014). Health Reform Minnesota, HCH, Health Care Homes. Retrieved on August 20, 2018, from:

<http://www.health.state.mn.us/healthreform/homes/outcomes/documents/evaluationreports/hchevalwebinar3142014.pdf>.

THE LEARNING COLLABORATIVE

The Learning Collaborative is an integral part of the HCH Program, with various resources available to clinics, including online learning opportunities, access to past webinars, and funding to develop peer-based learning communities to improve specific aspects of care. HCH has helped develop many learning communities, providing training, guidance, and funding. Each learning community created a curriculum, delivered trainings, evaluated their trainings, and shared a report of their findings.

In June 2018, MDH released an RFP to advance the work of HCH through strong partnerships between primary care and local public health or tribal health divisions, behavioral health, or other community-based organizations to use data to support shared population health goals. A total of three grants were awarded to the Lakewood Health System, North Memorial Health, and North Metro Pediatrics. Grant-

“We cannot underestimate the power of relationship building in these collective learning efforts. We all know we need to move beyond doing isolated impact work with communities. These projects provided a proof-of-concept for sharing data and using collaborative stakeholder know-how in a smart-design way for discovering collective impact population improvement ideas to address health challenges in communities. Along the way identified champions were key to helping foster and maintain the relationships and their focus on the shared vision.”

-Katie White, EdD, MBA

Associate Professor, Division of Health Policy and Management, School of Public Health, University of Minnesota

ees were asked to develop action plans and address how they planned to inventory data sources, engage community partners, examine capacity to use EHR data and other data sources, analyze data, and disseminate their findings.

To support the work of the grantees and HCH stakeholders, MDH contracted with ACET, Inc. to coordinate and support the work of the grantees and HCH stakeholders by:



Providing subject-matter expertise in the areas of partnership, collaboration, and data use;



Offering technical assistance to grantees and HCH staff to enhance existing partnerships;



Supporting grantees in identifying strategies and creating work plans to address a health priority using shared data;



Assisting grantees in accessing, analyzing, and disseminating data to stakeholders;



Being knowledgeable of the report entitled, “Connecting Communities with Data ” to develop curriculum to support trainings in collaboration with the HCH Learning Team; and



Supporting grantees in documenting progress, strengths, challenges, and incentives for partnership around data sharing.

CONNECTING COMMUNITIES WITH DATA

“A Practical Guide for Using Electronic Health Record Data to Support Community Health” was developed in August of 2017 by MDH. This guide served as the backbone for the Learning Community Grant. It shared how “Minnesota’s communities are recognizing the potential to collaborate across clinical care and local public health to improve the health of all people in their communities.” Further, it illustrates how “Electronic health records (EHR) data combined with public health data have the potential to help local public health and providers:

- identify high-risk areas and sub-populations;
- target interventions to vulnerable populations;
- monitor the impact of such initiatives over time; and
- overall inform population health assessments.”

The guide provides a summary of several other Learning Communities and partnerships while also outlining key steps to develop and garner partnership to exchange data.

- Inventory data resources
- Engage community partners
- Assess capacity to use EHR data and information
- Analyze, summarize, and distribute information

The guide ends by providing an overview of a number of projects, illustrating how the steps were followed and sharing a few of the key findings and outcomes. The document was instrumental in guiding the Learning Community grant.

ACET was contracted to facilitate the projects with the Learning Communities by providing guidance, trainings, and technical assistance. ACET documented its work along the way and in reflection, generated an updated guidance steps for partnerships to explore cross-sector data sharing.



The Three Learning Communities included in the 2018-2019 grant were:

North Memorial Health

The hospital partnered with Vail Place, a behavior health clinic, and Hennepin Public Health, a local public health department.

Lakewood Health System

The health system partnered with their internal behavioral health department and local public health department, Todd County Public Health.

North Metro Pediatrics

The clinic partnered with a behavioral health clinic, Lee Carlson Center, and a local public health department, Anoka County Public Health.

The following pages outline the process followed by ACET in facilitating the Learning Community grant with MDH. Along with a summary of the action items in each Step, an example has been provided from the Learning Communities. The examples illustrate one possible way to complete the action items in each step.

1. ASSEMBLE THE TEAM

MDH funded three collaboratives, each with 3 unique sectors, including certified Health Care Home clinics or health systems as the lead agency partnered with both a mental health agency and local public health. The project scopes and designs were broad and primarily dedicated to allowing staff the time to develop systems and processes to share and review data together. The project goal, as established by MDH for each Learning Community, was an implementation plan to carry the work forward after the grant. To help facilitate the project, MDH partnered with ACET to provide training and technical assistance to the Learning Communities.

2. ASSESS THE PARTNERSHIP

As a kick-off for the project, ACET facilitated a Data Capacity Assessment with each Learning Community. The tool was developed to help the learning communities understand their partner agencies, discussing items such as staff and leadership support, data analysis experience, quality improvement processes, and, as a group, their readiness to complete the objectives set forth by MDH for the project. The two-hour discussions illuminated both the strengths of the unique learning communities as well as the differences in the structure of each team.

3. INVENTORY DATA RESOURCES

Next, Learning Communities gathered their respective data, including Electronic Health Record, referrals, and population health surveys. Each agency type carried a unique set of data and area of interest. In brainstorming meetings, each shared what they observed in their datasets. Several agencies then cleaned and refined their data after early discussions. As the project continued, each Learning Community began to see patterns and trends across their agencies that generated interest for the communities to focus on. Once an area of focus was established, each began to pull specific indicators or data points that communicated an issue that they believed they could address as a Learning Community.

4. DEVELOP ACTION PLAN

Finally, the learning communities gathered and identified action steps to address the areas of focus that were identified through the process mentioned above. Their implementation plans included key details regarding actions to be taken, as well as the individuals responsible and the respective timelines for completion. Each were significantly different, with some establishing baseline data points and working on specific processes such as referrals, while others looked to broadly strengthen and refine partnerships to address challenges uncovered in the review of data.

1. ASSEMBLE THE TEAM: LET'S GATHER!

Bringing together the correct team of staff from one organization can be challenging enough, much less assembling a team of multiple organizations. It can be helpful to craft well-rounded teams, with several areas of expertise represented, rather than teams of one job title. For example, a data analyst and project manager are great positions to consider staffing the partnership with. The inclusion of multiple job categories and cross-departmental collaboration is essential to bring a variety of viewpoints and expertise to the project.

Other key staff to consider including are leadership to help provide support and high-level guidance as well as program staff, who will have practical knowledge on the implementation and data collection processes on the ground level.

CHECKLIST OF STEPS

- 1 Establish a lead agency with a project manager.
- 2 Incorporate key staff, keeping the core team small enough to be able to gather regularly.
- 3 Include others as appropriate for certain periods of the project.
- 4 Ensure clear representation from each partner organization to allow the project to continue forward.

The North Memorial Learning Community brought together a dynamic team. They started the project with key leadership from each organization as well as data analysts and project managers. As the project unfolded, there was a need to pull in clinical staff to help supplement the knowledge of the group. This process worked well where a core group of five to six staff were enhanced at key points by bringing in clinical staff and additional data analysts.



“While costly in terms of time and possibly resources depending on state or other support, this phasing-in period is also extremely valuable for learning together, team building, and creating a deliberative, planful culture rather than an impulsive or reactive mindset...”

Nathan Shippee, PhD
Associate Professor, Division of Health Policy and Management,
School of Public Health, University of Minnesota

RESOURCES

1. BUILD page
2. Forming Partnerships a. See the ‘tools’ tab

2. ASSESS THE PARTNERSHIP: WHO ARE WE?

Once the team is assembled, it is important to build a collaborative spirit and have an understanding of what each organization and individual brings to the team. Reviewing the team's capacity in key areas helps to develop a team environment and allow the partnership to deepen. Staff and leadership for the project in each organization, data analysis capacity, and experience in partnership development are just a few areas you may want to openly discuss as a partnership.

Engaging in honest conversation and understanding not only the current team, but also the potential stakeholders at each organization will enable the project to quickly move through challenges that may arise. For example, if you are looking to include a school partner in your project, it is important to know who has worked closely with schools and what those partnerships have looked like.

The North Metro Pediatrics Learning Community (and the other two learning communities) gathered to conduct a team assessment at the onset of the project. They met for two hours and spent the first part of the meeting getting to know one another and learning about each other's agencies. As they worked through the capacity assessment, they began to understand the leadership and programmatic strengths at both North Metro Pediatrics and Lee Carlson Center, while Anoka Public Health staff were skilled in data management and analysis. As the project unfolded, they were able to capitalize on the unique skill sets of the team.

CHECKLIST OF STEPS

1 Establish a kick-off meeting with the entire team present.

2 Assign a facilitator to lead a discussion of staff's experience and capacity for the project.

3 Compile results and share with the team.

4 Reflect on results, considering if others need to be brought in. However, the primary benefit is growing as a team and acknowledging the unique strengths each organization and individual brings.

"Different organizations, and different inter-organizational teams, have different levels of mastery around the domains of work required in integrating data, systems, and work. Organizations need to not only identify the key individuals who should be involved, but also what their levels of expertise are around domains including data and informatics, continuum of care, operations, and policy. This is important because it helps identify strengths and apportion tasks, shows the kinds of co-learning that can occur on teams, and may reveal gaps in knowledge or expertise which the team might need to shore up with added people or additional training."

Nathan Shippee, PhD
Associate Professor, Division of Health Policy and Management,
School of Public Health, University of Minnesota

RESOURCES

1. Data Capacity Assessment Tool (Appendix A)

3. INVENTORY DATA RESOURCES: WHAT DO WE KNOW?

HINT: This will be the hardest part of the project and will require the most time, both in terms of discussion and independent work.

Once the key members of the team are gathered and have an understanding of each other, it is time to start looking at the data! Each organization undoubtedly has access to different data sources and types and as you consider the shared population, you will begin to pull together a list of data sets. The first time this is discussed, it may feel like there is no direction on what to look for. One strategy to help combat this uncertainty is to discuss the mandatory reporting each organization does. These data sets are likely accessible and potentially already summarized. Key areas of overlay and commonality can spur further investigation and curiosity.

Beginning with what each organization has data on can help the conversation to develop. As each organization shares what they know and what they have access to, it becomes easier to refine and reduce the number of data points down to a manageable amount. Once a handful of data points or indicators are reached, it'll be important to document how they were obtained (analyzed) so they can serve as benchmarks for the pending efforts that will be taken.



RESOURCES

1. Data Dictionary (Appendix B)
2. Prioritization Map (Appendix C)

Lakewood Learning Community worked diligently reviewing their data. They began by reviewing as a team required reports and further defined search criteria, working closely with their population health department. After identifying trends in their data subsets, they compared these to the Minnesota Student Survey. The comparison of the two data sets were able to illustrate and provide depth to a challenge that they had seen before but not at this level of detail. The time spent analyzing the data allowed them to see the picture with more clarity. The process was cyclical in nature, with a clearer view of their population arising after each time reviewing their data.

CHECKLIST OF STEPS

- 1 Compile data sets, highlighting key findings in each.
- 2 Discuss where areas of overlap as well as unique data points.
- 3 Continue refining data sets until you have a few key indicators.
- 4 Document how you gathered or obtained your indicators in a data dictionary.

4. DEVELOP ACTION PLAN: LET'S ACT!

Finally, it is time to gather and identify action steps, or an implementation plan, to address the areas of focus identified above. An implementation plan includes key details regarding actions to be taken, as well as the individuals responsible and timelines for completion. The details of every implementation plan will be different, but all should map a way forward, acting on the data reviewed. Some plans establish baseline data points, working on specific processes such as referrals, while others look to broadly strengthen and refine partnerships to address challenges uncovered in the review of data.

It is important to understand what the data is saying and follow it, rather than trying to implement an intervention or program that has been applied before. To help Minnesota communities address health disparities, it is important to follow the data and allow fresh approaches to arise, rather than doing what has always been done.

Key Components of an action plan:

- Task: What should be done?
- Person Responsible: Who is going to do the work?
- Timeline: When will it be done?
- Deliverable: What will it look like when its complete?
- Steps for evaluation: How will we know if we need to change course?

RESOURCES

1. Implementation Plan (Appendix D)
2. Public Health best practices

CHECKLIST OF STEPS

1

Review what programs and initiatives are working on identified challenge.

2

Develop steps to address identified challenge.

3

Consider health equity (are our steps tailored for the priority population?).

THE HCH LEARNING COMMUNITY PROJECT GENERATED THREE VERY DIFFERENT IMPLEMENTATION PLANS:

The Lakewood community planned a specific intervention and leveraged partner school districts to reach their target population.

The North Metro Pediatrics Learning Community assigned tasks to each organization, including enhancing referral processes, improving measurements, and looking for funding sources to support cost-savings for patients.

The North Memorial Learning Community used the data review as a launching point for several further projects, including expanding hot-spotting services as well as partnership development of the long-term.

KEYS TO SUCCESS

The Learning Communities identified several keys to success while completing their projects.

Build Relationships.

Developing a strong team is certainly emphasized in the steps above but to succeed in the short and long term, building relationships is essential. Often, knowing partners beyond the contribution or task they've been assigned is overlooked. However, in working alongside organizations with priorities and changing dynamics, it is essential to be able to have the nuanced conversations. Building rapport with your partners will allow each to speak openly about how a project can be utilized most effectively, allowing the greatest collective impact. In short, build time in during the project and meetings to get to know the personalities and people, rather than just the job descriptions, of the team.



Follow the Data.

The structure and nature of most collaborative projects is that they require detailed plans and action steps. The nature of exploring data is in tension with a clean project plan. It requires the team to be curious and ask questions of the data, reviewing and analyzing in several iterations. Following the data means the project may feel stalled or progressing slowly at times. However, it is important to allow sufficient time for this phase of the project. Rushing or not taking the time to learn from the data will limit the project. Without setting aside time to fully understand what the data is saying, opportunities to learn and innovate may be missed.

Ask Around.

The individuals brought to the project will be the primary source of direction and influence on your project. However, utilizing the networks and connections with experts and professionals is invaluable in ensuring success. In the Learning Community grant, several experts were leveraged to enhance the projects. Legal experts consulted on the nuances of data sharing laws, professors shared insights into data analysis techniques using the appropriate data sources as well as best practices for addressing identified clinical challenges.

Additionally, there are learning communities who have gone through this process. There is precedent and learned lessons that others can share. While this document outlines many of these, it is not exhaustive. Leveraging the experiences of others will set up new projects for success.

IN CONCLUSION, the health of Minnesota depends on new and expanding cross-sector partnerships. The time and effort spent investing in data sharing will be the foundation for finding new and innovative ways to positively impact the communities in Minnesota. The steps and lessons learned shared in this document seek to encourage this and provide guidance on implementing a strong learning community.

LEARNING COMMUNITY SUMMARIES

NORTH MEMORIAL

LAKWOOD

NORTH METRO PEDIATRIC

<i>who</i>	North Memorial Health, Vail Place, Hennepin County Public Health	Lakewood Health, Lakewood Behavioral Health, Todd County Public Health	North Metro Pediatrics, Lee Carlson Center, Anoka County Public Health
<i>data</i>	Electronic Health Record (North Memorial, Vail Place), Accountable Care Organization data (North Memorial), Metro SHAPE Survey (Hennepin County Public Health)	Electronic Health Record (Lakewood Health), Minnesota Student Survey (Todd County Public Health)	Electronic Health Record (North Metro Pediatrics, Lee Carlson Center), Referrals between agencies (North Metro Pediatrics and Lee Carlson Center), Minnesota Student Survey (Anoka County Public Health)
<i>unit of review</i>	Generated maps of services provided, diagnosis and other demographics	Analyzed visit and diagnosis data as well as Minnesota Student Survey findings, identifying trends to be addressed	Analyzed visit, diagnosis, and referral data in conjunction with Minnesota Student Survey, resulting in options for each agency to take action
<i>intervention</i>	Explore high level partnerships and expand tracking of referrals for future leanings	Improve visit processes and follow-up with key risks groups. Partner with schools to expand mental health education	Expand referral processes, explore additional funding, partner with schools to expand mental health education

APPENDIX A

**Minnesota Department of Health (MDH)
Health Care Homes (HCH) Learning Communities
Data Capacity Assessment Tool (D-CAT)**

1. Date of Assessment:

2. Location:

Good morning (afternoon), thank you everyone for coming to the data capacity assessment meeting. I know most of us met at least once before, but it'd be great to do quick introductions again. Can everyone share their name, position, role on this project, and the last thing they googled?

Great. Thank you, everyone. I am glad to be here with you and am excited for our conversation this morning (afternoon). We have prepared a Data Capacity Assessment Tool (D-CAT) that we will be walking through together. This tool will help ACET, MDH, and the Learning Community understand where the areas of strength and areas for improvement are. We, at ACET, hope to gather information today that will help us tailor our technical assistance and training over the course of the grant.

In working with MDH, ACET is dedicated to supporting, encouraging, and facilitating the learning of each Learning Community to meet the objectives of the grant, namely, developing cross-sector partnerships to advance health for the populations you serve through the sharing of information. At the end of this project, we hope to have strengthened the relationships and networks of the Learning Communities, expanded the capacity and understanding for sharing and collectively reviewing data and information, and supported the development of an implementation plan with a focus on sustainable partnerships.

We are very excited to share with you two key resources also referenced at the MDH grantee kick-off meeting:

- **EHR Toolkit:** <http://www.health.state.mn.us/e-health/publications/docs/comdata-pophlth-toolkit.pdf>
- **MDH Learning Management System:** <https://mn.elogiclearning.com/Login.aspx>

Over the course of the next hour and a half, we will ask questions about four key areas: (1) staff and leadership support; (2) data analysis; (3) quality-improvement efforts; and (4) readiness to complete objectives. We would like to hear from you what you currently have in place at each of your organizations, as appropriate. We fully understand not all items will apply to each organization, but each element will be influential to the partnership as a whole. We also understand each item may not be applicable to this Learning Community, but we have developed a standard assessment across each Learning Community in effort to capture consistent data. As we review, some items may require discussion while others may be yes or no responses. This is okay. As we go over each item, we hope to have a bit of discussion to gather complete and thorough responses before we move to the next. We have around 40 items, so we will have time to discuss each. [ACET staff] and I will work to document our conversation today. Towards the end of our meeting, we will be handing out a self-reflection form that asks questions about your individual experiences in various topics and what you hope to gain from participating in your Learning Community. We will prepare a summary of the Data Capacity Assessment Tool and Reflection forms for MDH and your Learning Community but will keep individual responses confidential. Again, our hope is to learn how ACET and MDH can support this Learning Community in accomplishing the goals of the grant, and your honest and detailed responses are greatly appreciated.

Does anyone have any questions before we begin? [pause]

Okay, let's begin.

Data Capacity Assessment Tool (D-CAT)

Item	Response	Needs/Notes
Section I: Staff and Leadership Support		
A. How many people from your organization will support this project?		
B. What departments are supporting this project?		
C. Is there a champion identified for this project? If so, who is it?		
D. What are the leaders in your organization doing to support this project?		
E. Who at your organization provides data support for this project?		
F. Do you have an IT staff internally to help with technical challenges? If so, who is it?		
G. Are incentives/mutual benefits for each organization established and clear?		
H. What previous data/information has been shared within this partnership?		
I. What has been shared with external partners and what is their potential level of involvement?		
J. What areas of priority have been identified by your organization?		
K. Is there anything else about staff or leadership support that is important to know for this project?		
Section II: Data Analysis		
A. What kind of data do you review?		
B. How often do you review data?		
C. How often is aggregated data pulled from EHR?		
D. Who pulls data from your EHR?		
E. Who is responsible for mandatory reporting? Are they involved in this project?		
F. Do you have a patient/community survey? If yes, how often is the survey administered? If yes, is an aggregated report available? If yes, how have reports been shared?		
G. What is your current EHR structure (e.g., Epic, Cerner)? What, if any, challenges do you have accessing data from your EHR?		

Item	Response	Needs/Notes
H. Is your organization using any population health-data platforms in addition to or in conjunction with your EHR (e.g., Epic Healthy Planet)? If so, how are they currently utilized? If not, why not?		
I. Do you have a process in place to review or validate EHR data?		
J. What platforms do you use to collect and manage data? What, if any, challenges do you have utilizing these platforms? (Include data for PH and data not in EHR.)		
K. What statistical expertise does the group bring? What languages are team members familiar with (R, SPSS, SAS)?		
L. What external resources does your organization have to support data analysis? (Examples include cleaning and coding data in excel, developing pivot tables, and backgrounds in math and statistics.)		
M. What types of information has your organization shared in the past? And with whom has your organization shared this information?		
N. What systems do you use to share patient or client data? Other types of data?		
O. Do you aggregate data in a C-CDA? If so, does it follow the national standard for transport of PHI?		
P. Is there anything else about data analysis that is important to know about this project?		
Section III: Quality Improvement (QI)		
A. Do you have a quality-improvement team within your organization?		
B. How often does your quality-improvement team meet? Are any staff from this project on the team?		
C. What metrics have been given priority? What action plans have been developed in recent months?		
D. How often are these metrics reviewed and updated?		

Item	Response	Needs/Notes
Section IV: Readiness to Complete Objectives (Extremely, Moderately, Slightly, Not at all)		
A. How ready are you to complete the following items? What areas do you foresee needing technical assistance?		
1. <i>Work with MDH HCH staff to identify learning needs, approaches, and applicable best practices.</i>		
2. <i>Prepare an inventory of available data resources relevant to a shared population.</i>		
3. <i>Create a shared vision for the partnership with mutual expectations to share information that is supported by leadership of the health care home, its local public health or Tribal health division, and behavioral health partners.</i>		
4. <i>Assess capacity of partners to use EHR data, registries, local public health needs assessments, and other data sources.</i>		
5. <i>Use PDSA (plan-do-study-act) or other QI approaches throughout the process for continuous quality improvement.</i>		
6. <i>Develop a data dictionary with common language to promote understanding of terminology used across each of the partner agencies.</i>		
7. <i>Analyze and summarize information on the shared population they are serving.</i>		
8. <i>By June 30, 2019, develop an implementation plan with partners to address a health priority after the grant period is completed.</i>		

Section V:

1. What was not covered in the assessment that will be important to consider for this project?

**Minnesota Department of Health (MDH)
Health Care Homes (HCH) Learning Communities
Self-Reflection Questionnaire**

Directions: Please take a moment to reflect on your experience with various topics, goals for your Learning Community, and interest in participating in peer-to-peer exchanges. ACET will aggregate results for each Learning Community and share the findings with you and the Minnesota Department of Health. Your individual response will be kept private and will not be shared beyond the ACET team.

1. Name: _____
2. Organization: _____
3. Please rate your experience with the following topics using the scale below.
 - **4** = Advanced (studied details about the topic and provided guidance to others)
 - **3** = Intermediate (has a good working knowledge about the topic)
 - **2** = Basic (knows the topic enough to have brief conversation)
 - **1** = Limited (knows what the topics is, but that is it)

Topics	Rating
A. Developing public-private partnerships?	
B. Establishing external partnerships?	
C. Developing communication tools such as presentations or reports?	
D. Developing coalitions or collaboratives?	
E. Using spreadsheets such as Microsoft Excel?	
F. Interpreting descriptive statistics (e.g., proportions, means)?	
G. Doing data inventories?	
H. Using Community Health Assessment (CHA) data?	
I. Reviewing a Community Health Improvement Plan (CHIP)?	
J. Developing implementation plans used on data?	
K. Finding data from external sources?	
L. Interpreting data from external sources?	
M. Implementing Quality Improvement?	
N. Drafting data sharing agreements?	
O. Applying the Minnesota Health Records Act (MHRA)?	
P. Applying the Minnesota Government Data Practices Act (MGDPA)?	
Q. Using online portals to securely share information or data?	

4. If you rated any of the topics above as Intermediate or Advanced, would you be willing to write or reply to a peer that has limited to basic knowledge on that topic? If yes, please circle the topic(s) of interest from the list above.
5. Why is this project important to you?
6. What concerns do you have about this project?
7. What topic(s) do you want additional training in to help you advance the goals of this project?

Thank you!

APPENDIX B

Data Dictionary Outline

The fields below are to be completed for each indicator included in the Implementation Plan.

Indicator Name:

Indicator Definition: (brief description of the indicator, including a description of the numerator and denominator if the indicator is a rate / percentage)

Data Source: (where does the data come from? Specify if multiple sources are used to create the indicator: for example, if the numerator and denominator come from different sources)

Population: (what group or population is the indicator describing?)

Measurement Process: (who, what, when, where, and how will the indicator be calculated?)

Monitoring Timeframe: (how often will the data be collected and reviewed? Who will review the data?)

Trendline/Baseline: (the recent trend for the indicator and starting point, as available)

Target: (where we want to be with this indicator)

Objective Statement: (written with SMART criteria: specific, measurable, attainable, relevant, and time-bound)

Definition of Key Terms: (include a description of terms used, written in plain language)

Other Notes: (any other information that is relevant to the measurement of this indicator)

APPENDIX C

Prioritization Matrix

	Importance +	Importance -
Changeable +	High Priority for program focus	Low priority
Changeable -	Priority for innovative program	No program

APPENDIX D

Implementation Plan Template

Focus Area: _____

Objective: _____

Activity	Timeline	Lead Staff/Key Partners	Resources Needed

Plan to Access Resources:

Plan to Address Barriers: