The Impact of Community Health Needs Assessments

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Objectives

• Understand the fundamental importance of community health needs assessments to CAHs and the community

• Review the relationship of community health needs assessment to all core areas of the Flex Program

• Discover how state Flex Programs are using community health needs assessments

• Learn about recent research available from FMT
What is a Community Responsive Hospital?

- Look beyond delivery of medical care to role of hospital leadership in the following:
  - Community issues (e.g., substance abuse, domestic violence)
  - Critical health issues (e.g., oral health, mental health, obesity)
  - Health care equity (e.g., barriers to access or health status disparities among vulnerable populations)
  - System barriers (e.g., limited public health infrastructure, limited integration of providers and services)
  - Community's role in process (e.g., involve residents in addressing above issues, reducing risky behaviors, partnering with schools)

From: Where Do We Go from Here? The Hospital Leader’s Role in Community Engagement (2007) by the Health Research and Educational Trust.
Community Benefit and National Health Reform

Clinical Service Delivery • Community-Based Preventive Services

PAYMENT MODELS
Fee for Service • Episode-Based Reimbursement • Partial—Full Risk Capitation • Global Budgeting

INCENTIVES
Conduct Procedures • Evidence-Based Medicine • Expanded Care Management • Reduce Obstacles to Behavior Change
Fill Beds • Clinical PFP • Risk-adjusted PFP • Address Root Causes

METRICS
Net Revenue • Improved Clinical Outcomes • Reduced Preventable Hospitalizations/ED
Reduced Readmits • Reduced Disparities • Aggregate Improvement in HS and QOL
Reduced HC Costs
**CHNA and Community Benefit Business Model**

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2 (Where we are now)</th>
<th>Phase 3</th>
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<tr>
<td>Align program and services with the needs/location of insured populations</td>
<td>Focus on health disparities</td>
<td>Evidence-based seamless continuum of care</td>
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<td>Proprietary model</td>
<td>Emphasis on social determinants</td>
<td>Comprehensive, intersectoral approach to programs</td>
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<td>Random acts of kindness</td>
<td>Limited relevance to clinical services</td>
<td>Institutional financial incentives aligned</td>
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<td>Lack of financial incentives</td>
<td>One player in a balanced portfolio of investments</td>
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<td>Collaboration with community stakeholders</td>
<td>Collaboration with all Stakeholders</td>
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- **Phase 1:** Align program and services with the needs/location of insured populations. Use a proprietary model and random acts of kindness.
- **Phase 2 (Where we are now):** Focus on health disparities, emphasis on social determinants, limited relevance to clinical services, lack of financial incentives, and collaboration with community stakeholders.
- **Phase 3:** Evidence-based seamless continuum of care, comprehensive, intersectoral approach to programs, institutional financial incentives aligned, one player in a balanced portfolio of investments, collaboration with all stakeholders.
Status of IRS Guidelines

- Proposed (4/5/13) revisions do not substantially change obligations – additional guidance, greater clarity, and transition rules
  - Need only assess ‘significant’ health needs, not all health needs
  - Must seek input from public health department or equivalent
  - Hospitals permitted to conduct joint CHNA and adopt joint implementation strategy if certain conditions are met
  - Modifying requirements for making CHNA “widely” available (must remain on website until two subsequent CHNA reports are posted)
  - 4.5 month extension to adopt implementation strategy for 1st CHNA
  - Implementation strategy must describe anticipated impact of plans to address health needs, a plan to evaluate impact, and resources committed by hospital
Status of IRS Guidelines (cont’d)

• Identifying hospital facilities
  – Multiple buildings operated under one state license - single hospital
  – Hospital organization “operates” a hospital:
    o If it is a participant in a joint venture that operates facility and is treated as partnership for federal income tax purposes or
    o If it is a sole member/owner of a disregarded entity that operates hospital

• Regulations do not apply to activities that are unrelated to operation of a hospital facility, such as a separate facility not operated as a hospital
Status of IRS Guidelines (cont’d)

• Defining community served
  – Clarifies that hospital may include populations and geographic areas outside those in which its patient populations reside
  – Confirms that it may not exclude medically underserved, low income, or minority populations who are part of its patient populations

• Persons representing broad interests of community
  – Requires input from state/local public health or similar agency but allows hospital to chose most appropriate jurisdictional level
  – Persons with chronic disease are no longer identified as a separate category of persons who may not be excluded but are considered part of medically underserved populations
• Documenting CHNA

  – May summarize how and over what time period input was provided and the substance of the input
  – Must identify organizations providing input—not necessary to identify specific individuals from organizations or individuals participating in community forums, focus groups, or similar groups
  – Must describe medically underserved, low income, or minority populations being represented by organizations/individuals providing input
  – Written comments on CHNA/implementation plan must be considered
  – Must describe prioritized significant health needs and process/criteria used
  – Must include description of potential measures and resources available to address significant health needs
Status of IRS Guidelines (cont’d)

• Collaboration: Separate or joint reports and plans?
  – In general, each hospital must propose its own report
  – Proposed revisions allow collaborating hospital to produce a joint CHNA report and a joint implementation strategy if:
    o All hospital facilities define their community to be the same community;
    o Facilities conduct a joint CHNA process;
    o Resulting CHNA report and implementation strategy clearly indicate that they apply to the hospital facility;
    o Hospital facility’s particular role/responsibilities are clearly defined; and
    o Implementation strategy includes a summary or other tool to allow reader to easily locate those portions of the strategy that apply to the hospital facility
Status of IRS Guidelines (cont’d)

• Implementation strategy
  – Addresses an identified health need if the written plan:
    o Describes how hospital plans to meet the health need or
    o Indicates that hospital does not intend to meet a need and explains why.
  – Must describe anticipated impact of proposed actions, a plan for evaluating impact, resources/programs that hospital will commit to addressing need, and any planned collaboration to address need

• Extension: Completing strategy plan during 1st CHNA
  – Hospital has until the 15th day of the fifth calendar month following close of its 1st taxable year beginning after 3/23/12 for its authorizing body to accept its implementation plan (CHNA must be completed within 1st taxable year after 3/23/12).
CHNA Enhancement Strategy: Population Health

• Look beyond compliance and “legacy” activities
• Choose evidence-based strategies:
  – Centers for Disease Control and Prevention, Catholic Health Association, Public Health Institute, SAMHSA
  – Critically evaluate existing “legacy” activities
• Develop ways to measure and communicate progress
  – Develop performance indicators tied to community priorities
  – Share information with community – A crucial step in building trust
• Focus on charity/discounted care policies to expand access and reduce impact of delayed treatment
• Examine bad debt levels to understand access issues
• Most hospitals provide significant levels of charity/discounted care to low-income/uninsured individuals

• These individual account for unnecessary (and often uncompensated) emergency department and inpatient utilization

• Using CHNA results:
  - Establish focus areas for community health improvement and population health
  - Address the needs of low income and uninsured individuals
  - Develop services to reduce unnecessary utilization and uncompensated care (e.g., improve access, enhance coordination of care, tackle chronic disease and unmet health needs)
Top Community Health Responses

Community Health Concerns
• Alcohol/substance abuse
• Cancer
• Obesity

Criteria for a Healthy Community
• Access to health care
• Good jobs & a healthy economy
• Healthy behaviors & lifestyles

Average percentages based on CHNA data collected from 2007-2013
Access to Local Health Care

- 71% of respondents have utilized hospital services in last 3 past years
- 94% of respondents have utilized primary care in last 3 years
- 73% of respondents have utilized specialty care in last 3 years
- 23% of respondents delay receiving healthcare services when needed

Average percentages based on CHNA data collected from 2007-2013
Quality of Local Hospitals

• Overall quality of care from the local hospital: range is 2.86-3.65/4.00
• Overall quality of service from the local hospital: range is 2.93-3.51/4.00

Average percentages based on CHNA data collected from 2007-2013
Target Priority Issues

- Base activities on a current needs assessment
- Develop initiatives in response to utilization data
- Focus on expanding access to care and service vulnerable populations
- Engage board, staff, docs, clinicians, and community
- Establish leadership and accountability
- Collaboratively identify priorities and solutions
- Plan, manage, and measure
- Establish business case for program where possible
  - Value to the community
  - Reduction in local health care delivery costs
CHNA Examples from CAHs

• Regional Medical Center
  – Organized around 10 core areas of Iowa’s Health People 2010 criteria
  – Each committee had 6 to 9 community representatives
  – Hospital provided subtle leadership behind the scene
  – Increased trust and collaboration among community agencies

• Littleton Regional Hospital
  – Collaborative process between hospital, Ammonoosuc Community Health Services, and North Country Home Health and Hospice
  – Conducts joint community needs assessment every two years
  – Prepared by North Country Health Consortium
CAH Population Health Examples

• Nor-Lea General Hospital
  – Created the Heritage Program for Senior Adults in 2003 to provide outpatient mental health services to seniors
  – Staffed by psychiatrist, therapists, registered nurse, and mental health technicians

• Teton Medical Center’ Wellness Program
  – Collaboration with the high school, Teton Community Development Cooperative, County Extension Office, Great Falls Clinic, and others
  – Services include exercise programs, nutrition, health education, diabetes, stroke, and heart rehabilitation
  – Serves general community and has a special focus on health and fitness for high school students, firefighters, and persons with chronic illness
• Regional Medical Center
  – Development of a continuum of mental health services in three rural Iowa counties
  – Started with development of community mental health centers
  – Re-organized to provide behavioral health services through provider-based RHCs (due to changes in Medicaid funding)
Community Impact
Support for Quality Improvement

A CHNA process can support CAHs with:

- Identifying local perception of care & services
- Recognizing gaps & strengths of local health care services
- Enhancing care transition & patient safety initiatives
- Establishing benchmarks
A CHNA process can support CAHs with:

• Identifying opportunities to increase access to care
• Capturing greater patient volume within the service area by building customer trust & loyalty
• Enhancing operational processes for improved customer service
Support for Health System Development

CHNA process can support CAHs with:

• Detecting top community health disparities
• Developing initiatives to reduce community health disparities
• Increasing the community’s education on prevention & wellness
• Creating awareness of local health services
• Building partnerships in the community for increased care transitions & patient safety
Methods Developed by Flex Coordinators

- Budget flex funds to cover CHNA services from a vendor
- Offer group purchasing rates from vendors
- Provide CHA services “in house”
- Facilitate community partnership intros
- Aggregate data; establish baselines
CHNAs are About People
For More Information

Flex Monitoring Team- www.flexmonitoringteam.org
National Rural Health Resource Center- www.ruralcenter.org
Internal Revenue Service- www.irs.gov
National Center for Rural Health Works- www.ruralhealthworks.org
Community Commons- www.chna.org
NACCHO/MAPP- www.naccho.org/topics/infrastructure/mapp/index.cfm
Catholic Health Association- www.chausa.org/communitybenefit
CDC- www.thecommunityguide.org/index.html
Population Health Institute, University of Wisconsin- www.countyhealthrankings.org/roadmaps/what-works-for-health
Association for Community Health Improvement- www.assesstoolkit.org/assesstoolkit/index.jsp
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