Community Benefits Under Health Reform: Focus on Community Needs and Engagement

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Critical Access Hospital Meeting

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A Performance Monitoring Resource for Critical Access Hospitals, States, and Communities

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ACA Additions to Tax Code for Tax Exempt Hospitals

- Sections 501(r)(3)
  - Community health needs assessments every 3 years
  - Effective for tax years beginning after March 2012
- Sections 501(r)(4-6)
  - Financial assistance and emergency care policies; limitations on patient charges; limits on billing and collection practices
  - Effective for tax years after March 2011
- Each hospital in multi-hospital organizations must meet the requirements separately
- ACA expects tax-exempt hospitals to do what “good” hospitals are already doing – not a “gotcha” activity

Community Health Needs Assessment (CHNA)

- CHNA must:
  - Be conducted not less than every three years
  - Adopt strategy to address needs identified through CHNA
  - Incorporate input from persons representing the broad interests of the community, including those with interest/expertise in public health
  - Be made widely available to the public
- As part of its Form 990 filing, hospital must describe:
  - Its CHNA process
  - How it is meeting identified needs through CHNA
  - Any such needs that are not being addressed and why it chose not to address those needs

Additional Reporting Requirements

- Secretary of the Treasury shall:
  - Review the community benefit activities of reporting hospitals at least once every 3 years
  - Report to Congress on levels of charity care, bad debt, and unreimbursed costs for services for means- and non-means tested government programs incurred by **all** hospitals; and information on the community benefit activities of private tax-exempt hospitals
  - Report to Congress on trends in the above not later than 5 years after the enactment of the ACA

Penalties for Failure to Comply

- For provisions related to CHNAs, IRS will impose a $50,000 excise tax for any (and all) taxable year that a hospital fails to comply with these provisions
- Potential challenges to tax exempt status
- Hospitals will be expected to complete a formal needs assessment within its first full fiscal year beginning after March 2012

Status of IRS Guidelines

- IRS issued Notice 2010-39 requesting comments on additional requirements for tax-exempt hospitals by July 22, 2010
- Received close to 200 comments
- Revised Form 990 for 2010 will incorporate ACA changes related to Sections 501(r)(4-6) (financial and billing policies) but not Sections 501(r)(3) CHNA (due to later effective date)
- Hospitals must proceed despite lack of guidance as CHNA must be completed by end of tax year following March 23, 2012

What Should Hospitals Do?

- Begin CHNA process now
- Adhere to spirit of regulations – be transparent
- Partner with other groups/organizations in community
- Access existing public and population health data
- **Document** activities, sources of data, partners in process, sources of community input, and process of dissemination
- Move beyond comfort zone
  - Do not rely solely on traditional sources of input
  - Reach out to vulnerable populations, bring them into the process

Shifting from Counting Activities to Addressing Community Needs

- Many community benefit programs focus on counting dollars rather than the impact of activities and extent to which they address community needs
- Coming "full circle" to reconnect hospitals to their communities and **re-emphasize** their charitable mission
- Goal: move focus away from "random acts of kindness" to:
  - Community engagement
  - Collaboration between providers
  - Accountability to identified local needs
  - Focus on accessibility of services and prevention
  - Focus on population health issues

Community Engagement Issues

- Structural interests in health care tend to limit community input and community role in decision making
- Programs/services designed solely by "experts" will be skewed
  - Engaging citizens, community interest groups, and consumers is important to ensure broader values and perspectives are included
- No one model is right for all communities
  - There are good principles that can be used
  - Different ideological approaches may be needed for populations and stakeholders

Principles of Good Community Engagement Practice

- Process should:
  - Be legitimate and linked to service development and decision making
  - Well managed, facilitated, and resourced with time allowed for meaningful involvement
  - Use a variety of methods to engage participants with different preferences for participating
  - Be deliberative, clearly defined, and identify “communities” involved
    - Participants can discuss information provided, ask questions, put forward their own views, listen to others, and be part of decision making
  - Give participants feedback on findings and how their participation influenced process
  - Be monitored and critiqued for effectiveness

Activities to Build Integrated and Sustainable Delivery Systems

- Reach out to and enroll individuals into eligible programs
- Provide culturally competent medical homes
- Assure access to prevention and wellness services
- Address population health issues
- Provide access to affordable prescription drugs
- Assure access to specialty and hospital care
- Manage chronic care
- Coordinate comprehensive care
- Develop strategies to cover low-wage workers

Best Practices in Community Engagement

- Community engagement is:
  - An inclusive and ongoing process, involving a broad range of community stakeholders
  - Based on partnerships with community organizations, business, and local government including formal and informal leaders
- Engagement of local community champions is key to success
- Communication must be ongoing and active
- Project management must be flexible and responsive to changing local needs and interests

HRET's Description of a Community Responsive Hospital

- Look beyond delivery of medical care to role of hospital leadership in:
  - Community issues (e.g., substance abuse, domestic violence, etc.)
  - Health issues (e.g., oral health, mental health, obesity, etc.)
  - 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, etc.)
  - Community's role in process (e.g., involve residents in addressing above issues, reducing risky behaviors, partnering with schools, etc.)

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

Potential Partners by Issue Area

- Community: Schools, businesses/employers, elected officials, organizational trustees, faith community, media
- Health: Physicians, dentists, nurses, pharmacists, mental health specialists, community providers/agencies, insurers
- Equity: Community-based groups, activists, safety net providers, faith community, public health leaders
- System barriers: Health care and public health leaders, physicians, insurers
- Community's role: Patients/consumers, schools, service organizations, neighborhood associations, organizational trustees

Assessing Community Needs

- Two approaches (both are needed):
  - Identify and monitor community health problems through data driven needs assessments and performance management (“deficiency model”)
  - Directly involve local community members in making decisions about community health (“asset model”)
- Benefits of community engagement
  - Demonstrates hospital commitment to community
  - Increases community “ownership” of programs
  - May identify issues not revealed by a data driven assessment
  - Identifies areas for collaboration
  - Increases likelihood that initiatives will be successful

After the CHNA: Next Steps

- Choose evidence-based strategies:
  - CDC, Catholic Health Association, Public Health Institute, and St. Louis University School of Public Health are sources of potential evidence-based strategies to improve community health
  - Critically evaluate existing “legacy” activities
- Develop ways to measure and communicate progress
  - Develop performance indicators tied to community priorities
  - Look for and use proven tactics to address priorities
  - Share information with community using reports cards, community meetings, newsletters, reports, web sites, etc. – Sharing information is a crucial step in building trust

Examples of CAH Initiatives

- Regional Medical Center
  - Developed a continuum of mental health services in three rural Iowa counties - currently re-organizing to provide behavioral health services through provider-based RHCs
- Weiser Memorial Hospital's WACHAT Program
  - Washington/Adams County Health Action Team provides primary care for uninsured individuals
  - Collaboration of 18 community organizations, social service agencies, and providers in Weiser, Council, and Cambridge.

Examples of CAH Initiatives

- 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 MH technicians
- Teton Medical Center' Wellness Program
  - Collaborated with the high school, Teton Community Development Cooperative, County Extension Office, Great Falls Clinic, and others
  - Includes 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

OneMaine Health Collaborative CHNA Process

- Collaborative partnership between MaineHealth, Eastern Maine HealthCare Systems, and MaineGeneral Health
- Statewide CHNA providing data at the county level
- Telephone survey of 6400 Maine households
- Analysis of a wide range of secondary data
- Identification of priority health issues at state and county level
- Conducted by University of New England, Muskie School at USM, and Market Decisions
- Reports, data, and comparative county findings available - March/April 2011

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