

# *Practical Community Health Needs Assessment and Engagement Strategies*

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## *ACA Additions to Tax Code for Tax Exempt Hospitals*

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- 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
- Defines expectations for “good” hospital behavior



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## *Community Health Needs Assessment (CHNA)*

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- 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



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## *Oversight and Reporting Requirements*

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- 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



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## *Penalties for Failure to Comply*

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- 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



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## *Status of IRS Guidelines*

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- 2010 Form 990, Schedule H incorporates ACA changes for financial/billing policies and CHNAs
- CHNA to be completed within tax year beginning after 3/2012
- IRS has begun to review community benefit activities of tax-exempt hospitals (April 2011)
  - IRS will not notify hospitals that they are under review nor does it expect to contact hospitals for information
- Reviews will be based on Form 990 filings - **accuracy is key**
- IRS has delayed filing for hospitals required to file before 8/15/2011 as it implements changes in its systems



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## *Why Lose Sleep Over This Issue?*

- CHNA requirements were developed within the ongoing policy debate about hospital tax exemptions and community benefit
- Community benefit activities are “expected” to address identified community needs
- Hospitals must adopt strategies to address needs identified through CHNA (and, as applicable, explain why it has chosen not address needs identified)
- Linking CHNAs and community benefit is intended to bring **accountability** to the process
- IRS to examine community benefits and report to Congress



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## *Form 990 Questions on CHNA (Optional for 2010)*

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- What does the CHNA describe? (check all that apply)
  - Definition of the community served by hospital
  - Demographics of community
  - Existing community facilities/resources available to respond to needs
  - How data was obtained
  - Health needs of community
  - Primary/chronic disease needs and health issues of uninsured persons, low-income persons, and minority groups
  - Process for identifying and prioritizing health needs and services needed
  - Process for consulting with persons representing community's interests
  - Information gaps limiting hospital's ability to assess all of community's health needs



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## *Form 990 Questions on CHNA (Optional for 2010)*

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- Did the hospital solicit input from persons who represent the community served by it? If yes:
  - Describe the process used
  - Identify the person consulted
- How did the hospital make its CHNA available to public?
  - Hospital website
  - Upon request from hospital
  - Other (describe)



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## *Form 990 Questions on CHNA (Optional for 2010)*

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- If hospital addressed needs identified in CHNA, indicate how:
  - Adoption of implementation strategy to address community needs
  - Execution of implementation strategy
  - Participation in development of community-wide community benefit plan
  - Participation in execution of community-wide community benefit plan
  - Inclusion of community benefit section in operational plans
  - Adoption of budget for provisions of services identified in CHNA
  - Prioritization of health needs in community
  - Prioritization of services identified in CHNA that hospital will undertake
- Did hospital address all needs identified in CHNA?
  - If no, explain which needs were not met and why



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## *Key CHNA Strategies*

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- Incorporate CHNA into overall community benefit process
- Use available tools – don't reinvent the wheel
- Collaborate with others
- Define your community/service area
- Build on existing assessments and internal information
- Use existing, published data
- Plan to update the CHNA and implementation strategies
- Make the process sustainable



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## *CHNA Is Part of a Larger Process*





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## *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.



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## *What Should Hospitals Do?*

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- Begin now
- Adhere to spirit of regulations – be transparent
- Partner/collaborate with other community groups/organizations
- 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



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## *Assessing Community Needs*

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- 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



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## *Focus on Addressing Unmet Community Needs*

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- For purposes of the IRS, CHNA is an integral part of a tax-exempt hospital's community benefit obligations
- 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



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## *CHNA Process*

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- Plan and prepare
- Determine purposes and scope
- Identify data that describes the health/needs of the community
- Understand and interpret data
- Define and validate priorities
- Document and communicate results



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## *Step 1: Plan and Prepare*

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- Identify who in the hospital will lead program
- Determine who will participate in the process – create a team
- Identify community partners
- Engage board and executive leadership
- Determine how CHNA will be conducted
  - Will it be used by the hospital alone or multiple organizations?
- Identify and obtain available resources
- Develop preliminary time line

## *Coordinate CHNA Efforts*

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- Federal grantees, state/local health departments, FQHCs, etc have needs/mandates to conduct CHNAs
  - National voluntary accreditation program for PH departments requires a CHNA and a community health improvement plan
  - MAPP process for local health departments
- Find a way to coordinate efforts; maximize information, minimize cost
- Requires a broader focus; may be more time consuming and labor intensive; collaboration can be messy
- Benefits: greater involvement and acceptance by community, participants can share costs



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## *Step 2: Determine Scope and Purpose*

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- Ultimate purpose is to improve community health
  - Other purposes: support community based planning; internal hospital planning, secure grants, meet regulatory requirements
- Scope
  - Geographic area – may vary by service
  - Priority populations
  - Range of issues: Traditional health issues or social determinants of health
  - For collaborative CHNAs, determine hospital's needs coincide with and differ from those of partners – define core CHNA activities
- Revisit resources and time lines



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## *Step 3: Identify and Collect Data*

- Understand and review different types of available data
  - Quantitative vs. qualitative; primary vs. secondary
- Review/evaluate prior assessments and reports (if applicable)
- Describe community demographics
- Select indicators
- Identify relevant secondary data for indicators
- Collect community and public health input and feedback

## *The Challenges of Surveys*

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- Many equate CHNAs with conducting community surveys
  - Carefully and realistically evaluate the need for a primary survey
  - Can be a good source of data that is not available elsewhere
  - Can be costly and difficult to ensure statistical validity
  - Challenges : drawing a non-biased sample; cell phone, using non-validated survey questions
- Primary data collection is not recommended for many hospitals
- Becoming expert at finding and using sound, published secondary data is recommended



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## *Examples of Secondary Data Sources*

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- America's Health Rankings – (United Health Foundation)
- CDC Behavioral Risk Factor Surveillance System – Data
- CDC Data2010 for Healthy People 2010
- CDC Youth Risk Behavior Surveillance System
- Community Health Status Indicators, by County (DHHS)
- County Health Rankings (University of Wisconsin)
- Health.Data.Gov
- Health Indicators Warehouse (National Center for Health Statistics)
- Healthy People 2010 Data
- State Health Facts (Henry J. Kaiser Family Foundation)
- National Center for Health Statistics (general)
- National Library of Medicine - Data, Statistics & Tools
- Public Health Disparities Geocoding Project (Harvard SPH)



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## *Don't Forget State and Local Resources*

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- State, county, and local data resources
  - State vital records
  - Demographic data
  - Population-based cancer and other disease reporting systems
  - Behavioral health surveys
  - Public health surveillance systems
  - County and local public health data
- Hospital and emergency department utilization data
- Utilization and other community level data from community agencies, providers, schools, and partners



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## *Step 4: Understand and Interpret Data*

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- Analyze and interpret data
  - Comparison to other communities, the state, or the US
  - Identify trends
  - Use benchmarks
- Identify disparities
- Understand and identify causal factors
- Identify major community health needs – Identify:
  - Subset of population affected
  - Geographic area of focus
  - Specific health status problem or access issue being addressed



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## *Step 5: Define and Validate Priorities*

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- Determine who will be involved in the setting of priorities
- Establish criteria for setting priorities
  - Severity/magnitude of problem; historical trends, impact on vulnerable populations; feasibility of change; alignment with organization's mission, strengths, and priorities; resources to address the problem
- Identify priorities
  - Numerical ranking by groups or individuals
  - Assign weight to criteria established above
  - Discussion and debate
- Validate priorities
  - Input from community stakeholders, experts, and impacted populations



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## *Step 6: Document and Communicate Results*

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- Write the assessment report
  - Remember earlier questions from Form 990?
  - Describe process and findings
- Develop tables, graphs, and maps (if possible) to display data
- Disseminate results widely
  - Post on website
  - Community forums
  - Press releases
  - Speakers bureau

## *Obtaining Community Input*

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- Key informant/stakeholder interviews
  - Identify individuals with expertise in health and public health issues
- Internal staff
  - Physicians, nurses, staff, ER staff, case managers, social workers, community benefit staff, financial staff dealing with charity care requests, board members, and executive leadership
- Focus groups
  - Examples: internal staff, volunteers and the staff of human service and other community organizations, users of health services and members of minority or disadvantaged populations
- Community forums in a broad range of settings



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## *Community Engagement Issues*

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- 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



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## *Principles of Good Community Engagement Practice*

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- 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



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## *Potential Partners by Issue Area*

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- **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



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## *After the CHNA: Next Steps*

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- Develop an implementation strategy
- Choose evidence-based strategies:
  - CDC, CHA, Public Health Institute, and St. Louis University School of Public Health are sources of evidence-based strategies
  - 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 – A crucial step in building trust



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## *OneMaine Health Collaborative CHNA Process*

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- 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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## *Collaborative CHNA in Littleton, NH*

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- Collaborative partnership between Ammonoosuc community Health Services, Littleton Regional Hospital, and North Country Home Health and Hospice
- Conducted periodically – most recent report is November 2009
- North Country Health Consortium coordinates the assessment, develops survey instrument, and trains survey staff
- [http://www.littletonnhospital.org/pdf/Littleton\\_CNA\\_Final\\_Report.pdf](http://www.littletonnhhospital.org/pdf/Littleton_CNA_Final_Report.pdf)

## *CHNA Resources*

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- Rural Health Works Community Assessment Template
- Association for Community Health Improvement
  - Community Health Assessment Toolkit: <http://www.assesstoolkit.org/>
- Catholic Health Association-community benefit and CHNA
  - <http://www.chausa.org/communitybenefit/>
- National Association of County and City Health Officials
  - MAPP: <http://www.naccho.org/topics/infrastructure/mapp/>
- State health departments and public health agencies
- State hospital associations



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## *Community Engagement Resources and Tools*

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- Minnesota Department of Health Community Engagement website
  - [www.health.state.mn.us/communityeng/needs/needs.html](http://www.health.state.mn.us/communityeng/needs/needs.html)
- Asset-Based Community Development Institute at Northwestern University
  - <http://www.abcdinstitute.org/>
- Healthy People 2020
  - <http://healthypeople.gov/2020/default.aspx>
- University of Kansas Community Toolbox
  - <http://ctb.ku.edu/404.aspx?aspxerrorpath=/about/en>



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