Community Health Needs Assessments:  
Process and Results in North Dakota  

Presented to: North Dakota Hospital Association  
Board of Directors  

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Altru Health System  
Grand Forks, ND  

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Focus on  
– Educating and Informing  
– Policy  
– Research and Evaluation  
– Working with Communities  
– American Indians  
– Health Workforce  
– Hospitals and Facilities  

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Affordable Care Act

Mandates Community Health Needs Assessment (CHNA) be conducted every 3 years by all non-profit hospitals.

Enforced by: IRS
Penalties:
- $50,000 excise tax per year of non-compliance.
- Puts tax exempt status in jeopardy.

Need: (1) CHNA Report
(2) Implementation Strategy

Two sets of regulations issued so far: 2011 and 2013

CHNA Goals

Purpose:
1. Describe community health.
2. Present snapshot of health gaps, needs and concerns.

Goals:
1. Identification and prioritization of health needs.
2. Develop strategic implementation.
Affordable Care Act – 2011 Regulation

IRS Notice 2011-52 (July 7, 2011):

Guidance on assessment/report requirements. Some detail on what must be documented.

Primary focus:

• Take into account broad interests of community, including:
  • Public health
  • Medically underserved, low-income, minority populations, and populations with chronic diseases
  • Federal, tribal, regional, state, or local health depts. or agencies

Also set forth requirements of Implementation Strategy.

Affordable Care Act – 2013 Regulation

IRS REG-106499 (April 5, 2013):

• IRS relaxes stance on penalties: No penalty if failures to meet requirements were minor, inadvertent, and due to reasonable cause.

• Errors/omissions not willful or egregious will be excused if corrected and disclosed.
Affordable Care Act – 2013 Regulation

• Must identify “significant” needs, prioritize significant needs, and identify measures and resources to address those needs.

  • Determine whether need is significant “based on all the facts and circumstances present in community.”

Affordable Care Act – 2013 Regulation

• Examples of prioritization criteria include:
  • Burden, scope, severity, or urgency of the health need
  • Estimated feasibility and effectiveness of possible interventions
  • Health disparities associated with need
  • Importance the community places on addressing the need
  • But: Hospital “may use any criteria it deems appropriate.”
Affordable Care Act – 2013 Regulation

• Must take into account input from persons who represent the broad interests of the community, including those with special knowledge of, or expertise in, public health.

• At a minimum, must take into account input from:
  (1) at least one state, local, tribal, or regional governmental public health department;
  (2) members of community’s medically underserved, low-income, and minority populations, or individuals/organizations representing interests of such populations; and
  (3) written comments received on hospital’s most recent CHNA and implementation strategy.

Affordable Care Act – 2013 Regulation

• Must make CHNA report widely available to public.
  • Conspicuously post report on hospital’s website (or link to other website with report).
  • Report must remain on the website until two subsequent reports have been posted.
  • Must make a paper copy available for public inspection at hospital without charge.
  • May post draft of report without starting 3-year cycle.
Affordable Care Act – 2013 Regulation Implementation Strategy – Basics

For each significant health need, must:

1. Describe how hospital plans to address need
   a) Describe actions and anticipated impact.
   b) Identify programs and resources to commit.
   c) Describe collaboration with other facilities/organizations.

2. Or: Identify need as one hospital does not intend to address and explain why.
   • Brief explanation is sufficient.

Hospital must adopt implementation strategy in same taxable year CHNA is conducted.

Rural Community Group Model
**Rural Communities**

**Rural Community Group Model (RCGM)**
- Attend to word-of-mouth dissemination
- Recognize social capital within small towns
- Utilize CEO to gain entrée
- Utilize community leaders for distribution
- Beware of group think and social stigma

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**Methodology**

- Adapted from National Center for Rural Health Works

- Mixed methods
  1. Primary data
     a) Community Group – Focus Group
     b) Interviews
     c) Surveys
  2. Secondary data
RCGM Planning

Timeline: Two site visits

- 3-6 months to complete report
- Cost: $5-15,000 using hospital personnel-no charge for assessment and implementation planning from CRH through Flex grant
- $15-60,000 using outside consultants

Resources needed:

- Survey software
- 500-1,500 paper surveys per assessment
- Data entry
- Researcher/Facilitator
- Laptop & projector

Rural Community Group Model

Convene broad-based Community Group:

1. Meets at least twice.
2. Serves as focus group.
3. Reviews data and information to identify health needs.
4. Prioritizes needs.
Rural Community Group Model

Community Group composition
1. Represent broad interests of community
2. 15-20 individuals
3. Selected by CEO

Interviews & Focus Group
• One-on-one interviews held with key informants (6-8) who can provide insights into community’s health needs.
• Selected by hospital CEO.
• Must interview public health professional.
• IRB consent; limits of confidentiality.
• Topics include:
  • general health needs of the community;
  • awareness/use of health services offered locally;
  • suggestions for improving collaboration within the community,
  • barriers to local care; and
  • reasons community members use local health care providers, and reasons community members use other facilities for health care.
Survey of the Community

- Community survey looked at the following:
  - community assets,
  - awareness and utilization of local health services,
  - barriers to using local services,
  - suggestions for improving collaboration within the community,
  - local health care delivery concerns,
  - reasons consumers use local health care providers and reasons they seek care elsewhere,
  - travel time to the nearest local provider clinic and to the nearest clinic not operated by a local provider, demographics (gender, age, marital status, employment status, income, and insurance status), and
  - any health conditions or diseases respondents currently have.

Survey Dissemination

- **Medium**
  - Community Members: Paper copy (500 to 1,500) and online
  - Health Care Professionals: Online only

- **Advertising**
  - Community Members: Press release for newspaper, radio ads, website, word of mouth
  - Health Care Professionals: Paystub note, email, staff meeting, website

- **Distribution**
  - Community Members: Key informant and focus group participants distribute; local businesses, banks, churches, workout centers, service organizations, hospital and clinic, chamber of commerce
  - Health Care Professionals: Online
Q. 8 Health Concerns

<table>
<thead>
<tr>
<th>Concern</th>
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<tbody>
<tr>
<td>Access to needed technology/equipment</td>
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<td>Accident/injury prevention</td>
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<td>Addiction/substance abuse</td>
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<td>Adequate number of health care providers and specialists</td>
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<td>Cancer</td>
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<td>Diabetes</td>
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<td>Distance/transportation to health care facility</td>
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<td>Emergency services (ambulance &amp; 911) available 24/7</td>
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<td>Financial viability of hospital</td>
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<td>Focus on wellness and prevention of disease</td>
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<td>Heart disease (e.g., congestive heart failure, heart attack, stroke, coronary artery disease)</td>
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<td>Higher costs of health care for consumers</td>
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<td>Mental health (e.g., depression, dementia/Alzheimer’s)</td>
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<td>Not enough health care staff in general</td>
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<td>Obesity</td>
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<td>Suicide prevention</td>
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<td>Violence (domestic, workplace, emotional, physical, sexual)</td>
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b) How do these concerns impact your community?

Community Group - 2nd Meeting

- **Group members** are presented with:
  - Survey results
  - Findings from key informants and focus group
  - Secondary data relating to general health of service area
  - Tasked with identifying and prioritizing community’s health needs
CHNA Report – Regulatory Requirements

CHNA Documentation Requirements (cont’d)

2. Description of process/methods
   a) Describe data and how collected
   b) Identify collaborators/contractors

Assessment Methodology

- Pine Valley Medical Center serves an area in northwestern North Dakota and northeastern Montana. The majority of patients come from an area within a 60-mile radius.

Community Group

A Community Group consisting of 19 community members met on October 30, 2012. During this first Community Group Meeting, it was suggested that the community’s health needs be assessed.

Interviews

One-on-one interviews with key informants were conducted on October 30 and 31, 2012. A representative of the Center visited the Pine Valley Medical Center to conduct interviews.

Survey

A survey was distributed to gather feedback from community members. The survey was intended to be a scientific or statistically valid tool.

Secondary Research

Secondary data was collected and analyzed to provide a snapshot of the community’s health conditions, behaviors, and outcomes. Information was collected from various sources.

Secondary Sources Used

- U.S. Census Bureau
- North Dakota Department of Health
- Robert Wood Johnson Foundation’s County Health Rankings (which pulls data from 14 primary data sources)
- North Dakota Health Care Review, Inc. (NDHCRI)
- North Dakota KIDS COUNT
- National Survey of Children’s Health Data Resource Center
- Centers for Disease Control and Prevention
- North Dakota Behavioral Risk Factor Surveillance System
- National Center for Health Statistics
Emergent Health Trends in North Dakota

- Sample size = 39 hospitals (N=39)
  - 34 CAHs + 5 metro hospitals
- Aggregated individual CHNA data.
- Thematic analysis of prioritized list of needs
  - Workforce =
    - physicians + visiting specialists + nursing + health care professionals
  - chronic disease management =
    - cardiovascular health + diabetes + respiratory health

Significant Needs Across North Dakota

- Health care workforce shortages
- Obesity & physical inactivity
- Mental health (incl. substance abuse)
- Chronic disease management
- Higher costs of health care for consumers
- Financial viability of hospital
- Aging population services
- Excessive drinking
- Access to needed equipment/ facility update
- Emphasis on wellness, education & prevention
- Maintaining EMS
- Uninsured adults
- Marketing & promotion of hospital services
- Cancer
- Lack of collaboration with community
- Elevated rate of adult smoking
- Traffic safety
- Violence
- Lack of affordable housing
- Lack of daycare
- Low customer service & quality of care
Resources to Assist CAHs in Addressing Community Needs

- Flex grants
- Rural Health Outreach, Network Development, and/or Network Planning
- (new) public health funding
- Contact Rural Assistance Center (http://www.racolne.org/)
- CHNA web site http://ruralhealth.und.edu/projects/community-health-needs-assessment

Resources to Address Community Health Needs

- **Flex Grants – 2013-2014**
  - Hazen – archstruction consultant fees for feasibility analysis
  - Lisbon – community awareness and education-obesity prevention, healthy eating, wellness screens
  - Watford City – physician recruitment candidate site visit related costs
  - Langdon – community ed./awareness obesity prevention, healthy eating, phys. ed., cancer screening
  - Harvey – professional production of physician recruitment and hospital service awareness DVDs
  - Oakes-health coach program reduce unnecessary hospital readmission rates, inappropriate use ED
  - Carrington-wellness and disease management program
  - Turtle Lake- marketing of hospital services and workforce recruitment
  - Crosby-e-emergency
  - Garrison-marketing of hospital services and workforce recruitment
  - Rugby-telehealth connectivity with Altru
  - Northwood-weight management and physical activity program

- Focus is broad to reflect the needs that emerged from the CHNA process but 1st year of Flex funding CAHs to address community needs had these themes: health promotion/disease prevention, disease management (and reduce unnecessary hospitalizations), health workforce, marketing of hospital
What are Rural Health Outreach Grants?

• Federal rural health outreach grants support the direct delivery of health care and related services, to expand existing services, and to enhance health service delivery through education, promotion, and prevention programs

• Emphasis is on the actual delivery of specific services rather than the development of organizational capacity

• In this way they contrast with ORHP Rural Health Network Development grants where more of the emphasis is place on “building the network.”

• Both grant programs do require a network of three separate legal entities

What are the Limitations on Funds?

• Grantee cannot use the funds for the purchase, construction, renovation, or improvement of real property.
  o Funds, can, however, be used for the purchase/rental of equipment and vehicles up to 40% of the total annual federal share.

• Grantee cannot use funds for the delivery of direct patient care.

• Grantee cannot use funds to reduce or supplant existing levels of institutional and/or other non-federal financial support.

• Network members are expected to use grant funds in a collaborative manner and not to pursue individual projects that benefit only one member organization.
Center for Rural Health

Resources to Address Community Health Needs

• Rural Health Outreach Grants – federal grants from HRSA
  o 3 year grants
  o $200,000 a year starting for 2014 round (had been $150,000; $125,000; and $100,000 prior—significant increase in funding)
  o Requires a network of 3 separate legal organizations
  o Applicant must be rural and non-profit
  o Can have partner that is urban and/or for-profit
  o Common partnerships have been hospitals, public health, education
  o Program started 1991—one of oldest from Office of Rural Health Policy
  o 23 Outreach grants have been funded in ND since 1991 (ND one of leading states)
  o At least 17 rural hospitals involved as applicant or partner
  o 18 grants had a rural hospital
  o Dickinson in 4 Outreach grants; Wishek in 2

Center for Rural Health

Resources to Address Community Health Needs

• Rural Health Outreach Grants – federal grants from HRSA
  o ND Outreach Grants have Addressed the Following:
    o Community wellness, education, exercise (network from Park River to 8 smaller towns)
    o Health screenings, community health education — CAH, public health, community action agency—covered 8 counties (Dickinson)
    o Three-share program to increase insurance coverage — multiple hospitals
    o Mental health consortium — 4 CAHs (Bottineau, Harvey, Kenmare, and Rolla)
    o Behavioral health, telemedicine — CAH and tertiary hospital (Hazen and Bismarck)
    o Suicide prevention — CAH, public health, primary care clinic (Valley City)
    o Community wellness, education, exercise, chronic disease — CAH, public health, and Job/Economic Development (Langdon)
    o Chronic disease management — CAH, public health, multi-county service area
    o Prevention, screenings, chronic disease — CAH, public health, pharmacy, tertiary hospital (Wishek)
    o Alzheimer’s care, education, training — 2 CAHs and tertiary hospital
    o EMS — first responder training, pager system — CAH, tribal health, ambulance units, group home
Going Forward

• Started a new 3 year cycle – revamped survey
• Community health needs tend to be:
  o Population health – chronic disease management, prevention, health promotion
  o Hospital focused but critical to addressing and improving community health – workforce and hospital viability
• Collaboration
  o Hospital and public health
  o Hospital, public health, primary care
  o Other health organizations
  o Other important partners – school, business, economic development, human services, faith community, local government
  o Can we create a vision on a multi-community level? – networks across organizations and communities

Contact us for more information!

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