Webinar Tips & Notes

- Mute your phone &/or computer microphone
- Time is reserved at the end for Q&A
- Please fill out the post-webinar survey
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- Recording will be posted on the AzCRH www.crh.arizona.edu/ and the SWTRC www.southwesttrc.org/
Arizona State Office of Rural Health Monthly Webinar Series

Provides technical assistance to rural stakeholders to disseminate research findings, policy updates, best-practices and other rural health issues to statewide rural partners and stakeholders.

Thank you to our partners in delivering this webinar series:
Today’s presentation:

Rural Hospital Community Health Needs Assessment: Best Practices, Tips for Future Success, & Next Steps

Presenters:
Bryna Koch, MPH
Special Projects Coordinator, Arizona Center for Rural Health

Jennifer Peters
Arizona State Office of Rural Health Program Manager, Arizona Center for Rural Health
Learning Objectives

• Describe the development and purpose of the Community Health Needs Assessment (CHNA)
• Compare and contrast the health priorities identified by rural hospital CHNA’s and state level health priorities from the state health assessment and improvement plan
• Identify best practices and resources to strengthen future CHNAs
• Connect the shared health priorities and identify state level health improvement strategies that can be implemented in rural communities
Arizona Center for Rural Health

Est. 1981, serves AZ through its mission “to improve the health & wellness of rural & underserved populations”

1. State Office of Rural Health
2. Rural Hospital Flexibility Program
3. Small Hospital Improvement Program
4. Western Region Public Health Training Center
5. AzCRH Navigator Consortium

http://crh.arizona.edu
State Office of Rural Health (SORH)

- Funding via the Federal Office of Rural Health Policy (DHHS-HRSA)
- Provides an institutional framework linking rural communities with State and Federal resources to develop long-term partnerships and solutions to improve rural health
Arizona Rural Hospital Flexibility Program

Funding via the Health Resources & Services Administration

- Medicare Rural Hospital Flexibility Program
- Critical Access Hospitals
  - less than 25 inpatient beds
  - 35 miles or more from another facility
  - staff a 24-hour/7days per week Emergency Department
Arizona Rural Hospital Flexibility Program

Focus Areas:

• Quality Improvement
• Financial & Operational Improvement
• Population health management and EMS integration
• CAH designation
The purpose of a Community Health Needs Assessment (CHNA) is to identify key strengths, needs, and issues, using a systematic, comprehensive data collection and analysis process.
What is a Community Health Needs Assessment?

Best practices:

• Shared ownership of the process among stakeholders
• Broad community engagement – share updates, findings, and action steps
• Use a logical approach to gather information and address community priorities
• Process encourages flexibility and responds to challenges and opportunities
• Many excellent models and tool kits exist – a list will be provided
Why should community hospitals be EXCITED about a CHNA?

A CHNA is an opportunity to build on rural strengths!

• Health care is a local affair! A CHNA gives you the tools to make decisions that work for your community

• Health care delivered in rural communities is affordable, high quality, and necessary to the good health and economic sustainability of the entire community

• Most communities face a larger number and greater array of issues that usually acknowledged

• Effective problem-solving by communities is the most important factor in the survival of rural health services
Outcomes of the CHNA Process

Greater **community engagement** builds relationships and understanding

- Understand how community members view the hospital
- Understand how the hospital can more effectively meet community expectations

Shared **community health** goals

Strengthened health care services and identification of:

- What is going well?
- What needs more attention?
- Where can partnerships be formed?

Community is **invested in the future of their health system**
• **78%** of hospitals in the U.S. are non-profit entities

• Non-profit status supports “favored tax treatment” under federal, state, local, property and other taxes

• History of tax exemptions for charities – must demonstrate community benefit

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**1913**

First income tax code enacted. Includes exemptions for charitable orgs.

**1954**

Section 501 (c) (3) codified, federal tax exemptions for “religious, charitable, scientific, or education” organizations.

Qualification for tax-exempt status based on ability to provide free or reduced cost care to patients unable to pay.

**1969**

Requirement becomes generalized as demonstrating “community benefit.”

Includes spending that “promotes community health” + charity care.

**2008**

IRS added requirement to submit information on community benefit via the Form 990 Schedule H.

**2013**

Four new ACA requirements related to the community benefit are implemented, one of those new requirements is the CHNA.

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James, J (2016). Nonprofit Hospitals Community Benefit Requirements.
Community Benefit

78% of hospitals in the U.S. are non-profit

Private for-profit
Private non-profit
Public non-profit
non-profit

$24.6 billion
Estimated value of tax-exempt status

Distribution of Community Benefits

10% Research, education
5% Community health activities

85% related to patient care
CHNA in Action

• Increased attention to the community benefit requirement

• Community as the population served, not a collection of individual patients

• Desire to connect and integrate the public health/population level efforts and health care

Chuck Grassley Press Release
Catholic Health Association Survey of State Laws/Oversight Related to Community Health Needs Assessments and Implementation Strategies
Patient Protection and Affordable Care Act of 2010

- Chuck Grassley (R) Iowa
- Modeled after principles from the Catholic Health Association

For 2012, all 501(c)(3) hospitals must demonstrate community benefit to maintain tax-exempt status by completing a CHNA

- New to many, but 12 states had similar state level requirements

CHNA due every 3 years, make widely available, & adopt an implementation strategy to address needs

Chuck Grassley Press Release
Catholic Health Association Survey of State Laws/Oversight Related to Community Health Needs Assessments and Implementation Strategies
Opportunity to improve connection between health care and public health

Example from West Virginia

• No cost cancer screenings
• Expands on existing program but addresses transportation as a barrier in a specific county and will offer screenings locally
• Relies on greater partnerships with County Extension Office, County Senior Center, and local health clinic
What do CHANs for Arizona’s Rural Hospital

What does the CHNA process look like for Critical Access Hospitals and their rural communities?

- CAHs are an essential part of the rural health care infrastructure
- Rural is unique compared to urban/metropolitan areas & between rural communities
- Different demographic profile, health status, and social determinants of health
- Unique challenges & opportunities
Our Questions

• What are the similarities between CAH CHNAs?
• How are the health priorities identified by CAHs similar or different to the state health priorities?
• How can CAHs strengthen their next round of CHNAs?
• Reviewed 10 CHNA using the check-list type tool
• Synthesized results
Our Approach

Created a checklist-type CHNA review tool

Based on CHNA Best Practices from:

American Hospital Association

Catholic Health Association (CHAUSA)

Connecticut Hospital Association

Kaiser Permanente

National Association of County and City Health Officials (NACCHO)

Public Health Institute

Rural Health Works
CHNA Review Tool

- Background
- Shared Ownership
- Defining Community
- Data Collection & Analysis
- Types of Data
- Community Engagement
- Priority Setting
- Strategy Development
- Monitoring & Evaluation
- Public Reporting
What We Found

What are the similarities in health priorities?

1. Access to Care
2. Behavioral Health
3. Healthy Lifestyle
4. Needs of an Ageing Population
## What We Found

<table>
<thead>
<tr>
<th>Leading Public Health Issues</th>
<th>Access to Care</th>
<th>Mental &amp; Behavioral Health</th>
<th>Healthy Lifestyle</th>
<th>Ageing Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Health Assessment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority of Health Issue</th>
<th>1&lt;sup&gt;st&lt;/sup&gt;</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt;</th>
<th>Diabetes – 6&lt;sup&gt;th&lt;/sup&gt;</th>
<th>Obesity – 9&lt;sup&gt;th&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Health Improvement Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- CAH 1: X
- CAH 2: X
- CAH 3: X
- CAH 4: X
- CAH 5: X
- CAH 6: X
- CAH 7: X
- CAH 8: X
- CAH 9: X
- CAH 10: X

- CAH 1: X
- CAH 2: X
- CAH 3: X
- CAH 4: X
- CAH 5: X
- CAH 6: X
- CAH 7: X
- CAH 8: X
- CAH 9: X
- CAH 10: X
What We Found

1. Access to Care

Higher percentage of uninsured

Barriers to care

- Cost
- Transportation
- Availability of health care including specialty services
- Health professional shortages
- Patient education/knowledge
What We Found

2. Behavioral Health
   - Alcohol abuse
   - Substance abuse
   - Tobacco use
   - Depression
   - Suicide rates
What We Found

3. Healthy Lifestyle

• Leading cause of death data are preventable chronic diseases that can be prevented by modifying social determinants & addressing risks factors
What We Found

4. Needs of an Ageing Population

- Support for senior and home health
- Behavioral health specific to older populations
- Specialized care for dementia & other age related health conditions
What We Found

How do the CAH-CHNA health priorities differ from the state priorities?

1. Access to Care
2. Behavioral Health
3. Healthy Lifestyle
4. Needs of an Ageing Population
How can CAHs Strengthen CHNAs?

1. Improve integration of Social Determinants of Health Data
2. Develop strategies to address health priorities
3. Include evaluation & monitoring for each strategy
1. Improve integration of Social Determinants of Health Data

Of the 9 types of data recommended for inclusion in the CHNA, only 2 are based on health conditions.

5. Types of Data

- Disease incidence & prevalence
- Inpatient, emergency room, outpatient utilization
- Education, household income, unemployment
- Home ownership/rentals
- Arrests, incarceration
- Proximity of health food, food security
- Proximity of basic & social services
- Parks, recreation opportunities, open spaces
- Access to transportation, system quality
## 5. Types of Data

| Disease incidence & prevalence | ADHS Community Dashboard  
 County Health Rankings and Road Map  
 CDC Atlas ([Diabetes](https://www.cdc.gov/diabetes/), [Heart Disease & Stroke](https://www.cdc.gov/diseaseoutbreaks)  
 | CMS Mapping Medicare Disparities |
|---------------------------------|-------------------------------|
| Inpatient, emergency room,      | ADHS Community Dashboard  
 outpatient utilization  
 Education, household income,  
 unemployment  
 | American Community Survey via American  
 FactFinder  
 | Rural Data Portal (by county)  
 Policy Map |
| Home ownership/rentals          | ADHS Community Dashboard  
 American Community Survey via American  
 FactFinder (select metro areas)  
 Rural Data Portal (by county)  
 Policy Map |
<table>
<thead>
<tr>
<th>5. Types of Data</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrests, incarceration</td>
<td>Vera Institute of Justice (incarceration by county)</td>
</tr>
<tr>
<td></td>
<td>KidsCount Data Center (juvenile data by county)</td>
</tr>
<tr>
<td></td>
<td>Uniform Crime Reporting Statistics Data Tool</td>
</tr>
<tr>
<td></td>
<td>Arrests Data Analysis Tool</td>
</tr>
<tr>
<td>Proximity of health food, food security</td>
<td>County Health Rankings and Road Map</td>
</tr>
<tr>
<td></td>
<td>Policy Map</td>
</tr>
<tr>
<td>Proximity of basic &amp; social services</td>
<td>KidsCount Data Center (child care, head start)</td>
</tr>
<tr>
<td></td>
<td>DES Office Locator</td>
</tr>
<tr>
<td></td>
<td>Behavioral Health Treatment Services Locator</td>
</tr>
<tr>
<td></td>
<td>Policy Map</td>
</tr>
<tr>
<td></td>
<td>(SNAP retail locations)</td>
</tr>
<tr>
<td>Parks, recreation opportunities, open spaces</td>
<td>Local data (Google Maps!)</td>
</tr>
<tr>
<td>Access to transportation, system quality</td>
<td>American Community Survey via American FactFinder (means of transportation to work)</td>
</tr>
<tr>
<td></td>
<td>County Health Rankings and Road Map</td>
</tr>
<tr>
<td></td>
<td>Biking and Walking Benchmarks</td>
</tr>
</tbody>
</table>

**Resources**

- Economic Inequality Policy Map
- Residential Segregation County Health Rankings
What we Found

2. Develop strategies to address health priorities
   Only 1 CHNA reviewed included all the best practice components in the strategy development section

3. Include evaluation & monitoring for each strategy

8. Strategy Development
   - Strategies identified
   - Evidence provided
   - Policy change included as a strategy
   - Strategies assigned to responsible party
   - Community board approval
   - Hospital board approval
   - Timeline included

9. Monitoring & Evaluation
   - Outcome objectives identified
   - Impact objectives identified
Strengthening CHNAs

Review guidance from

American Hospital Association
Catholic Health Association (CHAUSA)
Connecticut Hospital Association
Kaiser Permanente
National Association of County and City Health Officials (NACCHO)
Public Health Institute
Rural Health Works
**Strengthening CHNAs**

### PRIORITY AREA 3: ACCESS TO HEALTH CARE

**Goal**: Increase Access to Quality Health Care, including Mental Health Services

#### Objective 3:1
By 2020, increase the percent of survey respondents who report being able to see a doctor when needed from 84% to 99%.

#### Strategy 3:1:1
Promote and share a comprehensive web-based resource guide for the public that lists all key Gila County health care services, starting with mental health services.
- Ensure 2-1-1 Arizona (Gila) is up-to-date with current organizations and resources.
- Promote 2-1-1 Arizona.
- Establish a work group that includes all staff and organizations already developing mental health service resource lists.
- Design and implement a community feedback system to ensure ongoing access and utilization.

**Lead Organization**: GCDHEMI

**Collaborating Organizations**: CVRMAC, Banner Payson Medical Center; Community Bridges, Southwest Behavioral Health Services

#### Strategy 3:1:2
Implement a social media and promotional campaign to educate residents on web-based resources and One-Call.
- Educate community about the resource.
- Coordinate with and utilize data from One-Call.

**Lead Organization**: GCDHEMI, CVRMAC

**Collaborating Organizations**: Banner Payson Medical Center

### MENTAL HEALTH, ALCOHOL & SUBSTANCE ABUSE

**GOAL #1**: To affect state, county and local policy changes that allow and implement diversion from jail and/or prison for individuals diagnosed with mental illness and/or substance use disorder (SUD).

**Objective**: Reduced incidence of incarceration for MH/SUD and increased incidence in participation in community programs

#### Strategy 1
- Complete a community capacity assessment: Identify and map all existing resources and gaps (including eligibility, access and coverage) for MH and SUD in Cochise County.

#### Strategy 2
- Develop a broad-based education and training program on MH/SUD for law enforcement, first responders, community providers and volunteers regarding a comprehensive approach to diversion.

#### Strategy 3
- Develop a systematic and sustainable communication structure among law enforcement, judicial, resources and providers who are involved with MH/SUD.

#### Strategy 4
- Ensure Cochise County is engaged and involved in all statewide resources, regulations and initiatives for MH/SUD, including the opioid crisis.

**Evidence-base and Resources**
- Arizona 2-1-1 [http://www21azarizonagila/]
Strengthening CHNAs

For each Health Priority

- Goal
  - **SMART** Objective(s)
  - Strategies
  - Implementation details
  - Evaluation Measures

**GOAL:** Reduce Substance Use Disorders to protect the health, safety, and quality of life for all, especially children

**OBJECTIVE:** Reduce the number of opioid overdoses/deaths

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>LEAD HOSPITAL(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses multiple CADCA strategies</td>
<td>SJMA, SJMC, UMHS</td>
</tr>
<tr>
<td>Support the WHI Opioid Project’s ongoing work, which includes the following seven areas:</td>
<td></td>
</tr>
<tr>
<td>1. Provider education (provide information and education, training)</td>
<td></td>
</tr>
<tr>
<td>2. Hospital ED policies (training, modify policies)</td>
<td></td>
</tr>
<tr>
<td>3. Medication diversion (provide information and education, provide support, reduce access to opioids, change physical design)</td>
<td></td>
</tr>
<tr>
<td>4. Pain patient support (provide support)</td>
<td></td>
</tr>
<tr>
<td>5. Harm reduction / naloxone administration (provide information and education, build skills/training, increase access to naloxone, modify policies)</td>
<td></td>
</tr>
<tr>
<td>6. Addiction treatment / recovery (provide information and education, provide support, increase access to treatment, recovery as a positive consequence)</td>
<td></td>
</tr>
<tr>
<td>7. Community education (provide information and education, provide support)</td>
<td></td>
</tr>
</tbody>
</table>

**PLANS TO EVALUATE IMPACT:**

<table>
<thead>
<tr>
<th>QUALITATIVE METRICS</th>
<th>QUANTITATIVE METRICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment of numbers from all bullet points</td>
<td>Number of self-reported opioid use reduced</td>
</tr>
<tr>
<td>Community education sessions</td>
<td>Naloxone opioid overdose reversals</td>
</tr>
<tr>
<td>Trainings for providers</td>
<td>Red barrel stations &amp; pounds medications take back</td>
</tr>
<tr>
<td>Report on policy changes</td>
<td>Number of individuals each year who are accessing care for opioid use treatment</td>
</tr>
</tbody>
</table>
Next Steps: Leverage Alignment

Steps
1. Review [State Health Needs Assessment](#)

Table 2: Arizona’s Leading Health Priorities

<table>
<thead>
<tr>
<th>Health Priority List</th>
<th>8. Maternal &amp; Child Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Access To Care</td>
<td>9. Obesity</td>
</tr>
<tr>
<td>2. Behavioral Health Services</td>
<td>10. Oral Health</td>
</tr>
<tr>
<td>3. Cancer</td>
<td>11. Substance Abuse</td>
</tr>
<tr>
<td>4. Cardiovascular Disease &amp; Stroke</td>
<td>12. Suicide</td>
</tr>
<tr>
<td>5. Chronic Lower Respiratory Disease (CLRD) &amp; Asthma</td>
<td>13. Tobacco</td>
</tr>
<tr>
<td>7. Healthcare-Associated Infections (HAIs)</td>
<td></td>
</tr>
</tbody>
</table>
2. Review State Health Improvement Plan

If your CHNA identified priorities, but not strategies, review the AZHIP strategies to look for alignment

What strategies makes sense for your hospital/org?

**Access to Care Strategies At-A-Glance:**

- Target outreach efforts to populations who struggle with access to care.
- Expand payment and delivery models to include additional provider types and preventive services that improve health outcomes.
- Improve the health literacy of consumers.
- Increase incentives and leverage funding streams to address identified workforce shortages.
- Support the expansion of Patient- and Family-Centered Medical Homes for comprehensive, high quality and accessible community health care.
- Support Arizona’s Medicaid Program.
- Ensure adequate networks in rural, underserved areas and tribal populations.
Next Steps

2b. Review **State Health Improvement Plan**

Who is doing the work, how can you participate, how can you lead?

Identify the partners and organizations working in this area

<table>
<thead>
<tr>
<th>Access to Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Health Insurance Coverage</td>
</tr>
<tr>
<td><strong>Community Initiatives</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Community Organization(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Health Insurance Exchange administration; health insurance community meetings; exchange planning activities</td>
<td>Arizona Department of Insurance, in coordination with the Arizona Governor’s Office of Health Insurance Exchange</td>
</tr>
<tr>
<td>Arizona Medicaid programs; Arizona Medical Assistance Program</td>
<td>Arizona Department of Economic Security, along with Arizona Health Care Cost Containment System</td>
</tr>
<tr>
<td>Life Enhancement Assistance Program (LEAP)</td>
<td>Maricopa County Department of Public Health</td>
</tr>
<tr>
<td>Cover Arizona</td>
<td>Coalitions of various AZ organizations</td>
</tr>
<tr>
<td>Pima Community Access Program (PCAP)</td>
<td>Pima County</td>
</tr>
</tbody>
</table>
Next Steps

3. Use the state health improvement plan to help inform your strategy selection

Select strategies that
Meet your community need
Leverage your expertise
Are relevant & meaningful
Are feasible

Resources
Arizona State Health Assessment & Health Improvement Plan
Substance Abuse
Suicide
Access to Care Brief
Diabetes Brief
Healthcare Associated Infections Brief
Next Steps

- Create an evaluation and monitoring plan
- Arizona Center for Rural Health can help!
- Contact Bryna at brynak@email.arizona.edu or Jen Peters at petersjs@email.arizona.edu
Questions

"GREAT THINGS ARE DONE BY A SERIES OF SMALL THINGS BROUGHT TOGETHER"

- VINCENT VAN GOGH -

Thank you!
Thank you
Questions?
Your opinion is valuable to us
Please participate in this brief survey:

https://uarizona.co1.qualtrics.com/jfe/form/SV_cYcwp8ianGvOmyN

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