Research Findings Brief

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An Assessment of the Community Health Needs Assessments and Implementation Plans for Nonprofit Small Rural Hospitals in Nebraska

David Palm, PhD, Li-Wu Chen, PhD, MHSA, and Jamie Larson, MBA

Research Highlights

- Based on the most recent Community Health Needs Assessments developed by all nonprofit small rural hospitals in Nebraska, the most common highest priorities were behavioral health issues and obesity and overweight issues.
- Most of the hospitals (70.5%) worked extensively with the local health department in their area to prepare the plan and determine the priorities and the majority of CHNAs received input from low-income, underserved, and minority populations.
- When the Community Health Needs Assessments were compared to the IRS requirements, all of them defined the service area, provided a description of the planning process, contained a list of community needs, and the priority needs. However, most CHNAs failed to discuss the gaps in available resources and the impact of previous intervention strategies.
- When comparing the implementation plans to the IRS requirements, most of them described the goals, strategies, and action steps as well as the role of the hospital in the implementation process, but only a small percentage discussed in some detail the role of their partners or the evaluation process and methods.
- The highest priorities identified by the hospitals were behavioral health and obesity issues followed by access to care, chronic disease prevention and screening (e.g., diabetes and hypertension), and cancer.
- To make significant progress on these difficult and complex population health needs, the hospital, the LHD, and other partners need to work together to develop a cohesive implementation strategy.

Introduction

The Patient Protection and Affordable Care Act (ACA) requires all nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) and an Implementation Plan (IP).[1] This requirement helps nonprofit hospitals to determine how the allocation of community benefit funds could be used to improve population health outcomes and create a more integrated health care system between the medical care system and the public health system. According to the final Section 501(r) regulations issued by the Internal Revenue Service (IRS), all nonprofit hospitals must develop a CHNA every three years. The CHNA must also define the community served, obtain input from those representing the broad interests of the community, identify the process and methods used to assess the needs, establish priorities and describe the methods used to determine the priorities, and make it widely available. The IP must describe how the hospital plans to address the priority needs (e.g., goals, strategies, and action steps, identify the role of the hospital and its partners in the implementation of the strategies, describe the process for evaluation, and make it widely available. [2]

Support for this project was provided by the Nebraska Office of Rural Health in the Department of Health and Human Services. For further information, contact David Palm, david.palm@unmc.edu, (402)559-8441, Department of Health Services Research and Administration, College of Public Health, University of Nebraska Medical Center, 984350 Nebraska Medical Center, Omaha, NE 68198-4350.

Nebraska Center for Rural Health Research

Methods

In this study, the CHNAs and IPs were examined for 34 nonprofit small rural hospitals in Nebraska. All the hospitals except one were critical access hospitals (CAHs) and the non-CAH had less than 50 beds. The most recent (i.e., usually 2016) CHNAs and IPs were obtained from the hospital web sites although some telephone calls were made to follow up on the IPs. To assess the quality and completeness of the CHNAs and IPs, each one was evaluated against the criteria listed in Appendix A. These criteria reflect the major requirements that were included in the final regulations released by the IRS. The priorities were also identified and listed in broad categories.

Results

In Table 1, the quality and completeness of the CHNAs and IPs for the nonprofit small rural hospitals in Nebraska are revealed. As expected, most hospitals (70.5%) worked closely with their local health department (LHD) in the development of the CHNA. This involvement often involved preparing the CHNA, analyzing secondary databases, conducting a local survey, organizing focus group interviews, and participating in the priority setting process. The LHD played a fairly major role in the CHNA in another 18% of the hospitals but had only a limited involvement in about 12% of them. In about two-thirds of the CHNAs, hospitals received input from low-income, underserved, and minority populations. However, this requirement was only partially met in 15% of the CHNAs and there was no input documented in about 20% of them.

The CHNAs were very complete in several areas, including the definition of the service area, the description of the process, a list of community needs, a list of priorities, and making it availability on the hospital's web site. For most hospitals, the service area was a single county (88%) and over 60% of the hospitals collaborated with the LHD to apply the Mobilizing for Action through Planning and Partnerships (MAPP) planning process to develop their CHNA. Because the MAPP process uses a variety of assessment techniques, including an analysis of secondary data sources, local surveys, and community meetings, the hospital is very likely to meet nearly all of the IRS requirements.

There were two areas where most CHNAs were incomplete and improvements are needed. The first area was the description of the resources available to meet the priority needs. Although the majority of CHNAs provided a list of available resources, very few (15%) discussed the gaps in some detail. The second incomplete area was a description of the impact of previous intervention strategies. In this case, only about 40% of the CHNAs included this discussion and 56% did not mention this impact. Most hospitals simply provided a list of activities that were undertaken as compared to a rigorous analysis of the impact of these activities.

Table 1 - Quality and Completeness of the Community Health Needs Assessments for Nonprofit Small Rural Hospitals in Nebraska (n=34)

CHNA	% Yes/Extensive	% Partially/Some	% No/Limited
Role of LHD	70.5%	17.6%	11.8%
Input from low-income, underserved populations	64.7%	14.7%	20.6%
Service area defined	100% (88.2% single county)	0.0%	0.0%
Description of Process	100% (61.8% used MAPP)	0.0%	0.0%
List of community needs	100%	0.0%	0.0%
List of Priorities and priority methods	100%	0.0%	0.0%
Description of resources available	14.7%	67.7%	20.6%
Impact of previous strategies	41.2%	2.9%	55.9%
Adoption by Board/available on web site	100%	0.0%	0.0%

Source: Information obtained from the 2015 or 2016 community health needs assessments located on the hospital's web site.

Table 2 summarizes the quality and completeness of the IPs relative to the IRS requirements. In most IPs, the goals, strategies, and implementation activities were discussed (79.4%). However, the level of detail varied considerably. For example, some IPs included measurable objectives and very specific action steps that would be taken by the hospital or one of its partners (e.g., assist patients in enrolling in Medicaid, develop an EAP plan in the local school, expand the use of tele-psychiatry mental health services, and increase the number of people who participate in CDC's Eat Right, Get Fit Program). In contrast, there were several implementation plans that included vague strategies and action steps (e.g., create a preventive health screening program, explore providing a suicide prevention program, and promote weight management by encouraging more people to make healthy choices). Without specific measurable objectives and activities, it will be very difficult to measure the impact of these actions.

The IP must also address the role of the hospitals and their partners in the implementation activities. Over 70% of the hospitals identified their role in these activities, but only about 12% of the IPs discussed specific roles for their partners. Without strong partnerships, it is very difficult to improve the population health outcomes related to obesity, physical activity, and screening for colon cancer and hypertension. Very few hospitals (14.7%) included a good description of the evaluation process and potential indicators to measure the impact of the actions taken. Finally, all but two facilities placed their IP on the hospital's web site.

Table 2 - Quality and Completeness of the Implementation Plans for the Nonprofit Small Rural Hospitals in Nebraska (n=34)

CHNA	% Yes/Extensive	% Partially/Some	% No/Limited
Description of Goals, Strategies	79.4%	11.8%	8.8%
Role of Hospital	70.6%	17.6%	11.8%
Role of Partners	11.8%	35.3%	52.9%
Description of Evaluation Process	14.7%	17.6%	67.6%
Adoption by Board/on Web Site	94.1%	0.0%	5.9%

Source: Based on the 2016 Implementation Plan from the hospital's web site.

High Priority Needs

One of the most crucial steps in the planning process is to determine the high priority needs. To reach this step, most hospitals examined secondary databases such as mortality rates for the leading causes of death, the Behavioral Risk Factor Surveillance System, and the University of Wisconsin's County Health Rankings. Many hospitals also conducted local surveys and held some type of community meeting to gather input from people in the community. To review the data and set priorities, most hospitals formed a coalition composed of representatives from various organizations in the community, including the local health department. In most cases, the coalition used specific criteria such as the magnitude of the problem, the readiness of the community to address the issue, and the availability of resources. Table 3 summarizes the priorities that were identified.

Table 3 - Highest Priorities among the Nonprofit Small Rural Hospitals in Nebraska

Specific Area	Percent and Number of Hospitals
Behavioral health/mental health/substance abuse/suicide	76.5% (26)
Obesity/overweight/physical activity	73.5% (25)
Chronic disease prevention and screening (diabetes, hypertension, heart disease, and stroke)	32.4% (11)
Access to care	32.4% (11)
Cancer	29.4% (10)
Violence and injury prevention	8.8% (3)
Aging issues (arthritis, hearing, etc.)	8.8% (3)
Family issues/parenting support	8.8% (3)
Maternal and child health/prenatal care	8.8% (3)
Breast feeding	2.9% (1)
Aging of primary care providers	2.9% (1)
Increase number of visiting specialists	2.9% (1)
Age of nursing home facilities	2.9% (1)

Source: Information obtained from the 2015 and 2016 Community Health Needs Assessments and Implementation Plans.

This table shows that behavioral health and obesity-related issues were the highest ranked priorities among the hospitals in the study Over 75% of all hospitals included behavioral health as one of their priorities and slightly less than 75% rated obesity as a priority. These problems have ranked consistently high for several years. For example, an analysis of the 2013 CHNA priorities found that behavioral health was rated as the third highest priority and obesity was identified as the second highest priority. The next three most highly rated priorities were access to care (32%), chronic disease prevention and screening (32%), and cancer (29%). In 2013, access to care was rated as the highest priority and cancer and diabetes were the fourth and fifth highest priorities. Although the results of this study indicate that access to care is still a significant problem in rural areas, it is no longer the number one issue. This decline may be due to an increase in the number of people with health insurance coverage due to the subsidies available in the ACA and hospitals and other organizations helping low-income people to enroll in Medicaid.

The priorities in small rural hospitals were also compared with those from the 20 urban and regional nonprofit hospitals in Nebraska. In these nonprofit hospitals, the top five priorities were:

- Access to care – 95% (19)
- Behavioral health – 80% (16)
- Injury and violence prevention – 75% (15)
- Obesity/overweight/physical activity – 60% (12)
- Heart disease and stroke – 30% (6)

The most significant differences in the priorities between small rural hospitals and larger urban and regional facilities were access to care (32% in rural and 95% in urban and regional) and injury and violence prevention (9% in rural and 75% in urban and regional). In rural areas, access to care is also reflected in behavioral health and the availability of some preventive services. In injury and violence prevention category, most of the emphasis in urban and regional areas was on the aspect of violence where homicide rates and other violent crimes are substantially higher than in rural areas.

Discussion

Based on the IRS requirements, most small rural hospitals can successfully develop a CHNA. A large part of this success is working closely with the LHD in the area. Although improvements were made in the IPs between 2013 and 2016, there is still wide variation in the specificity of the goals, strategies, and action steps. The role of the hospital in the implementation process is clearer and better documented than in 2013, but the role of the partners and the evaluation process and methods need considerable improvement.[3] One way to improve the evaluation process is to develop a work plan that includes measurable objectives and targets and clearly identifies the responsibilities of the hospitals and the other partners.

Because of the comprehensive planning process used by nearly all hospitals, the priorities are based on the needs of the population and are consistent with the priorities included in the community health improvement plans created by LHDs. While the priorities are identical or very similar, the strategies and action steps in the IPs generally appear to be fragmented and not based on a cohesive community implementation strategy. While the roles and responsibilities of partners should vary, they should be part of a cohesive package otherwise it will be difficult to demonstrate significant improvements on these complex population health issues.

References

1. Patient Protection and Affordable Care Act, 42 USC. 18001 et seq. (2010).
2. Federal Register. (2014). Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of section4959 Excise Tax Return and Time for Filing the Return. Retrieved from http://federal register.gov/a/2014-30525.
3. Kate Trout, david Palm, and Li-Wu Chen, “Current State of Community Health Needs Assessments (CHNAs) in Nebraska’s Small Rural Hospitals,” Research Findings Brief, Nebraska Center for Rural Health Research, November 2015.

Appendix A

Criteria Used to Evaluate the Quality and Completeness of the CHNAs and Implementation Plans for Nonprofit Hospitals in Nebraska

Community Health Needs Assessments (CHNAs)

1. Role of LHD – Extensive involvement (prepared the plan and helped shaped the priorities); Some involvement (provided and helped to analyze the data, part of planning committee that developed priorities); Limited or no involvement (consulted but otherwise not involved)
2. Input from low-income, medically underserved, and minority population groups (Yes/Partially/No) – [Key informant interviews, focus group interviews, and/or community meetings]
3. Service areas defined (e.g., county) and rationale provided (Yes/Partially/No)
4. Description of process (e.g., MAPP), including data sources and methods (Yes/Partially/No)
5. List of community needs (Yes/Partially/No)
6. List of priorities and methods for setting priorities (Yes/Partially/No)
7. Description of resources available to address the needs (Yes/Partially/No)
8. Impact of previous CHNA strategies (e.g., percentage of targets met) [Yes/Partially/No]
9. Adoption by board and placed on web site (Yes/Partially/No)

Implementation Plan

1. Description of goals, objectives, and strategies; rationale for not addressing some needs (Yes/Partially/No)
2. Role of the hospital in implementation (Yes/Partially/No)
3. Role of partners in Implementation (Yes/Partially/No)
4. Description of the evaluation process (Yes/Partially/No)
5. Adoption by board and placed on web site (Yes/Partially/No)