

A National Conversation on Community Health Assessments: Convened by NACCHO on Feb. 10, 2011



Purpose

The National Association of County and City Health Officials (NACCHO) invited key leaders from public health and healthcare organizations to share experiences, information, and expectations regarding community health assessments. The meeting, which occurred on Feb. 10, 2011, had a specific goal: To identify how national associations can support effective, efficient, and collaborative community health assessment and planning.

Robert Pestronk, Executive Director of NACCHO, advised the group that, although the meeting had been convened by NACCHO, the challenges and opportunities to share thinking and to form a basis for a common understanding and shared purpose belonged to all the organizations and individuals represented.

Background

This conversation represents a unique convergence of nonprofit hospitals, community health centers, and public health agencies having incentives or requirements that include community health assessments and related planning processes and products.

Public Health

Although community health assessments and community health improvement plans have been part of the conventional wisdom and approach for public health agencies and, in some states, a requirement for state support or certification, a new incentive is now driving activity. In 2011, the Public Health Accreditation Board (PHAB) will begin its first accreditation actions. In order to apply for PHAB accreditation, a public health agency, whether local or state, must have three prerequisites in place: community health assessment, community health improvement plan, and a strategic plan. Based on NACCHO survey data, 63 percent of local health departments (LHDs) have completed a community health assessment, and 49 percent have completed a community health improvement plan in the last three years. These prerequisites have given new urgency and importance for agencies to develop these instruments and processes if they

intend to seek accreditation. The requirement will likely be that the prerequisites must have been completed within the past five years.

Non-profit Hospitals

The provisions of the Affordable Care Act require a community health assessment by non-profit hospitals every three years. These provisions state that the assessments must include input from persons who represent the broad interests of the community and persons with special knowledge of or expertise in public health. These assessments must be widely available to the public.

Community Health Centers

The Bureau of Primary Health Care of the Health Services and Resources Agency requires federally qualified health centers (FQHCs) to apply for new grants every five years. The foundation for the FQHC application is a community health assessment. The program model is that the assessments lead to the strategic plans that shape the health centers' programs. The guidance states that "crafting strategy demands a thorough knowledge of the community and populations groups a health center intends to serve."

Thus, a community health assessment requirement exists for multiple players and providers in any given community. Opportunities for shared effort, results, and programming to support a local community appear to exist. In some communities, this shared work exists, but those examples are, perhaps, unique and exemplary, rather than typical and routine.

Meeting Summary

Hospitals

A presentation by Julie Trocchio of the Catholic Health Association of the United States illustrated how modern hospitals continually assess and address the needs of the community through strategic planning, structured community health assessments, and community benefit plans. There are both state and federal requirements as evidenced in state law and regulation, the IRS Form 990 Schedule H, and new

requirements under the Affordable Care Act. She stated that public health data and public health expertise are useful and needed. Tools used by hospitals include the Association of Community Health Improvement's Toolkit, CHA's Guide to Planning and Reporting Community Benefit, and such tools as NACCHO's Mobilizing for Action through Planning and Partnership (MAPP). A new requirement for hospitals is the mandate that the public have access to the assessments. She stated, "The opportunity for partnerships is remarkable. CEOs in hospitals are now really interested." She provided examples from Boston, California, and Minnesota, where hospitals and other community partners have worked well together to assess their community and plan for improvement.

The Association for Community Health Improvement (ACHI), an arm of the American Hospital Association, offers a community health assessment toolkit. The language is oriented to the hospital setting but uses public health approaches. In addition, VHA Inc. has a tool developed by numerous partners called "Health Assessment: A Process for Positive Change," which is about a collaborative approach to improving community health. Information about the assessments and other community benefit activities is available. Form 990s may be obtained from hospitals or from www.quidestar.com, following a twomonth lag. The forms do not lend themselves to a database of information, but the public health services research community is being encouraged to work with the data and measure impact. Community Catalyst is a partner with the Association of Schools of Public Health (ASPH) on this research.

Community Health Centers

David Stevens of the National Association of Community Health Centers presented an overview from the perspective of community health centers. Two drivers for the centers are the community health assessment as a foundation for programs and the opportunity for the clinics to be patient-centered medical homes. Community clinics are expected to double in size to serve 40 million patients. The needs assessments and planning, which are required every five years as part of the Health Resources and Services Administration's (HRSA's) competitive application process, are based on the service area, the target population, and the patients. Health status indicators and conditions amenable to prevention are part of the assessments. Stevens spoke about the opportunity to work together to improve health information technology. HRSA uses a system that reconciles zip codes and other data called http://udsmapper. org/about/cfm. The Uniform Data Set (UDS) Mapper is an interactive Web atlas designed to inform users about the current geographic extent of U.S. federally (Section 330) funded health centers. The tool assists in evaluating the geographic reach, penetration, and growth of the Section 330-funded Health

Center Program and its relationship to other federally linked health resources (www.nachc.com/toolsforresearch.cfm).

Public Health

Julia Joh Elligers of NACCHO presented LHD community health assessment information. A community health assessment is defined as "a process that uses quantitative and qualitative methods to systematically collect and analyze health status within a specific community." NACCHO survey indicates that 63 percent of LHDs have completed an assessment in the past three years. Some LHDs indicated that they were the primary player in developing the community assessment; others were partners or part of a coalition. In some cases, the assessments did not involve the LHD. Although LHDs can use numerous frameworks for the assessment, MAPP is consider the public health "gold standard" with its four assessments that lead to action planning and implementation. No organization has imposed uniformity or standards on public health assessments, with the exception of some state agencies that, as part of their contractual relationship with LHDs, may have specified minimal requirements.

Kevin Hutchinson of St. Clair County, IL, presented information regarding how a coalition of major health providers and community-based organizations were convened by the St. Clair County Board and the Public Health Board for coordinated planning. They have a vision of "partners for health improvement through prevention," with a focus on mobilizing private and public sectors for healthcare progress. Hutchinson cited their principles of identifying strategic issues:

- Collaboration not competition;
- Coordination not control;
- Communication with confidentiality;
- Common goals with consideration of individual
- Capitalizing on community strengths; and
- Collective commitment to community health improvement.

They used the MAPP framework for their five-year plans. They focused on strategic alignment to achieve their goals, involving non-profits, public health, community health centers, hospitals, employers, schools, the faith community, and the public.

Rebecca Rayman of the East Central District Health Department and the Good Neighbor Community Health Center, which are located in rural Nebraska, discussed the cooperative work in her community. Rayman directs both the public health agency and the community clinic and also serves on the hospital board. Her service area covers 2,219 square miles in four counties, and her community uses the MAPP framework. Nebraska requires

that district health departments develop a community health improvement plan for public health and recommends the use of MAPP. The community health center is required to do a needs assessment, which is based on the MAPP assessment. Like St. Clair County, her agency involves all the local potential partners, and all partners rely on one survey of the community. In Nebraska, hospitals and LHDs are encouraged to work together, and a guide to collaboration has been developed.

Recommendations and Challenges

The participants met in small groups to consider how the national associations can support local collaboration and how the associations might work together. They also explored barriers and challenges to that collaboration. Other groups that might also be part of the conversation were identified, including health plans, the American Medical Association, United Way, and city planners.

Themes of the Dialogue

Several themes emerged during the discussion, including barriers and opportunities for collaboration.

Definition of Community

Barriers include the different service boundaries in a community for the various partners. For example, an LHD could have multiple hospitals in its jurisdiction, or conversely, the hospital service area may cross multiple public health agency jurisdictions and clinic service areas. The players may not be accustomed to working together, and the partners may fear that they will be presented with problems that they do not want to own, as those problems are outside their area of expertise and mission or outside their jurisdiction or service area. All parties have to justify their definition of community to their regulator or funder. Community may be better defined in conjunction with partners that may have unique reaches into segments of the community. Some institutions, such as children's hospitals, have a regional or national service area. There is a need and desire to have the concept of community considered scalable, going from zip code to regions if needed.

Purpose of Assessments

The various sectors share the overall goal of assessments, to improve the health of the community and improve community health indicators. An emphasis may be on the primary clientele demographic, but the sectors look at social determinants and broader community issues as impacting their mission and goals. The shared goal of community health improvement provides an important platform for collaboration. Prevention is a shared goal for the various membership organizations.

Community Engagement and Collaboration

All of the sectors use principles of community engagement for a meaningful assessment. A desire to share guidelines and approaches for community engagement emerged from the meeting. Collaboration in gaining involvement from and input from the community can lead to reduced costs and avoid "engagement fatigue" from partners in the community. Collaborative approaches are well received in communities, and the partners can add to the richness of the involvement as they draw from certain unique segments of the population. The national associations that were represented at the meeting can draft recommendations about a collaborative approach at the local level. Examples of collaborative successes can be shared across memberships. A national task force could be named from the various organizations to show how partners can collaborate and communicate among the members. The organizations could present at each other's meetings and conferences about the willingness and need to collaborate.

Data and Resources

Public health data were frequently cited as a source that hospitals and community health clinics can access. Use of public health data reduces costs and enhances reliability by going to recognized and valid sources. Sharing community surveys is a way to reduce costs and avoid over-surveying communities. Examples exist of times public health provided and analyzed data from its areas of expertise with hospitals supporting community surveys. Creating and using common frameworks and data sets may lead to both improved results and reduced costs. Hospital data and community health clinic data are valuable indicators of needs and gaps. More opportunities will rise from broader use of electronic medical records.

The participants noted that the organizations can share education materials, training opportunities, technical assistance, and websites. Websites could be developed to show collaboration at the local and national levels.

Numerous assessment frameworks and data sources were identified. Many frameworks are similar, and MAPP is sometimes used across the sectors. All participants indicated an interest in sharing tools and frameworks and receiving technical assistance.

Periodicity Challenges

In addition to the challenges of defining community and geographical boundaries for assessments, a recurring barrier to collaboration is inconsistent timelines. Hospitals have three year CHA cycles; whereas CHCs and LHDs often have five year CHA cycles. The group could work with decision-makers and regulators toward harmonization of the cycles for assessments in the communities.

Summary

Although full collaboration faces many challenges, many opportunities exist. Issues of turf, history, competition, cultural differences, politics, and the need for local champions willing to take risks are potential barriers. Nevertheless, the participants identified many opportunities to support their members in collaboration at the local level. Several participants voiced their desire for continued dialogue. Appreciation was shown for NACCHO's role in convening the conversation and hopes were expressed for future progress.

Participants

- Ivy S. Baer, Director and Regulatory Counsel, Association of American Medical Colleges
- Stacey Barbas, Program Officer, Kresge Foundation
- Ron Bialek, President, Public Health Foundation
- Michael Bilton, Executive Director, Association for Community Health Improvement, American Hospital Association
- Pamela Byrnes, Director, Health Center Growth and Development, National Association of Community Health
- Anita Cardwell, Senior Associate, Community Services County Services Department, National Association of Counties
- Angela L. Carman, Doctor of Public Health Candidate, University of Kentucky, College of Public Health
- Liza Corso, Acting Branch Chief, Agency and Systems Improvement Branch, Division of Public Health Performance Improvement, Office of State, Tribal, Local, and Territorial Support, Centers for Disease Control and Prevention
- Jessica Curtis, Project Director, Hospital Accountability Project & Staff Attorney, Integrated Care Advocacy Project, Community Catalyst
- Teresa Daub, Public Health Advisor, Performance Standards and Accreditation, Office of State, Tribal, Local, and Territorial Support, Centers for Disease Control and Prevention
- Connie Evashwick, Senior Director of Academic Programs, Association of Schools of Public Health
- Marie Fallon, Chief Executive Officer, National Association of Local Boards of Health
- Donna Folkemer, Director, Hospital Community Benefit Program, Hilltop Institute, University of Maryland, Baltimore
- Maeghan Gilmore, Program Director, Community Services County Services Department, National Association of Counties

- Grace Gorenflo, Senior Director, Accreditation Preparation & Quality Improvement, National Association of County and City Health Officials
- Seiji Hayashi, Chief Medical Officer, Bureau of Primary Health Care, Health Resources & Services Administration
- Iane Hooker, Assistant Vice President Quality, National Association of Public Hospitals and Health Systems
- Xiaoyi Huang, Assistant Vice President of Policy, National Association of Public Hospitals and Health Systems
- Kevin Hutchison, Health Director, St. Clair County Health Department (IL)
- Julia Joh Elligers, Director, Assessment, Planning & Workforce Development, National Association of County and City Health Officials
- Lilly Kan, Senior Analyst, Community Health, National Association of County & City Health Officials
- Chris Kinabrew, Associate Director, Government and External Affairs, National Network of Public Health Institutes
- Barbara Laymon, Senior Analyst, Assessment and Planning, National Association of County and City Health Officials
- Jeffrey Levi, Executive Director, Trust for America's Health
- Jennifer McKeever, Program Manager, National Network of **Public Health Institutes**
- Chuck Milligan, Executive Director, Hilltop Institute, University of Maryland, Baltimore County
- Neena Murgai, Chronic Disease Epidemiologist, Alameda County Department of Public Health (CA)
- Quyen Ngo-Metzger, Chief, Data Branch, Office of Quality and Data, Bureau of Primary Health Care,
- Health Resources and Services Administration
- John O'Brien, Special Assistant on Health Financing, Office of the Administrator, SAMHSA
- Jim Pearsol, Chief Program Officer, Public Health Performance, Association of State and Territorial Health
- Cidette Perrin, Senior Director, Government Relations, VHA Inc., Office of Public Policy
- Robert Pestronk, Executive Director, National Association of County and City Health Officials
- Mary Pittman, President & CEO, Public Health Institute
- Rebecca Rayman, Executive Director, Good Neighbor Community Health Center, East-Central District Health Department
- Steven J. Rixen, Government Relations Representative, VHA Inc., Office of Public Policy
- Kathryn Wehr, Program Associate, Robert Wood Johnson
- Yolanda Savage, Project Director, Performance Standards & Accreditation, National Association of Local Boards of Health



- Donna Shelton, Director, Child Health Policy Research & Analytics, National Association of Children's Hospitals and Related Institutions
- Susan Sherry, Deputy Director, Community Catalyst
- Lauren Shirey, Director, Assessment & Planning, National Association of County and City Health Officials
- Jessica Solomon Fisher, Director, Accreditation Preparation & Quality Improvement, National Association of County and City Health Officials
- Indu Spugnardi, Director, Advocacy & Resource Development, Catholic Health Association
- Paul Stange, Senior Policy Advisor, Office of Prevention Through Healthcare, Office of the Associate Director for Policy, Centers for Disease Control and Prevention
- David Stevens, Associate Medical Officer & Director of NACHC Quality Center, National Association of Community Health Centers
- Geri Tebo, Public Health Advisor, Department of Health and Human Services, Office of Disease Prevention and Health Promotion
- Lee Thielen, Consultant
- Julie Trocchio, Senior Director, Community Benefit/ Continuing Care, Catholic Health Association of the United States
- Robin Wilcox, Chief Program Officer, Public Health Accreditation Board
- Bonnie L. Zell, Senior Director, Population Health, National Quality Forum

References

 Department of Health and Human Service Health Resources and Services Administration Bureau of Primary Health Care. Memo: Health Center Program Expectations. (1998). Retreived on May 11, 2011, from ftp://ftp.hrsa.gov/bphc/ docs/1998pins/pin98-23.pdf.

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The mission of the National Association of County and City Health Officials (NACCHO) is to be a leader, partner, catalyst, and voice for local health departments in order to ensure the conditions that promote health and equity, combat disease, and improve the quality and length of all lives.

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