

## NEEDS ASSESSMENTS

# Engaging rural Georgians in Internal Revenue Service (IRS)-mandated community health needs assessments

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## ABSTRACT

**Background:** On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA) into law. The law became effective on March 23, 2012. The ACA stipulates that non-profit hospitals must demonstrate benefit to their communities through the process of community health needs assessments (CHNAs). Failure to comply with this law may result in loss of non-profit status or large fines. This report describes strategies for engaging rural communities in Internal Revenue Service (IRS)-mandated CHNAs.

**Methods:** Public health practitioners from Georgia Southern University's Jiann Ping Hsu College of Public Health collaborated with 18 rural, non-profit hospitals to complete community-specific CHNAs. Quantitative and qualitative data were gathered from primary and secondary data sources to provide a comprehensive assessment of the needs and the assets of each of the communities.

**Results:** The project team assisted 18 rural, non-profit hospitals in assessing the needs of their communities. Technical reports provided to the hospitals described the issues discovered during the assessment. Hospitals were empowered to utilize the information to prioritize community-specific issues and to develop comprehensive plans for implementation.

**Conclusions:** The CHNA process provides an opportunity to strengthen relationships between public health services and hospitals as well as between hospitals and the communities they serve. Hospitals need to identify and engage diverse sectors of the community in order to comprehensively assess the needs and assets of communities to address the social determinants of health and to reduce health inequities/disparities.

**Keywords:** community health needs assessment, health status, rural health, public health standards, Affordable Care Act

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## INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) signed by President Barack Obama on March 23, 2010 requires all nonprofit, tax-exempt (501c3) hospitals to complete a community health needs assessment (CHNA) every three years to evaluate the health needs and assets of the communities they serve (Internal Revenue Service (IRS), 2013). In addition, these hospitals are required to develop an implementation strategy designed to address priorities identified through the assessment process. Hospitals that do not complete this mandated activity risk losing their nonprofit status and face a \$50,000 penalty (Community Health Needs Assessments for Charitable Hospitals, 2013). The ACA, which became effective on March 23, 2012, is regulated by the IRS (IRS, 2013).

In the IRS-mandated CHNAs, the following information must be included: 1) a written description of the

community served as well as a description for how the community is determined; 2) the specific processes and methods used to include data sources, data collection and analytical methods; and 3) the contribution from federal, tribal, regional, state, or local health departments as well as from leaders, representatives, or members of medically underserved, low-income, and minority populations. Upon completion of the CHNA, hospitals must present a written plan that addresses each of the identified community health needs (IRS, 2013).

The CHNA process presents an opportunity to strengthen relationships between public health personnel and hospitals as well as between hospitals and the communities they serve (Hatcher, 2015). CHNA reports have historically centered on an individualized medical model rather than a broader, more holistic public health model (Pennel et al., 2015). Thus, partnerships with public health institutions may lead to a more comprehensive assessment of health

inequities/disparities and the social determinants of health in rural communities (Hatcher, 2015). As defined by the Institute of Medicine (1988), assessment is one of the three core functions of public health (along with policy development and assurance). Although community assessment is a complex and dynamic process, the overarching goals of assessment are to monitor health status to identify community health problems; diagnose and investigate health problems and health hazards; and evaluate effectiveness, accessibility, and quality of personal and population-based health services (Institute of Medicine, 1988).

Approaches to preparing CHNAs in rural communities should take into consideration their different characteristics. Since rural communities often have a scarcity of financial resources, social capital (networks of relationships among people) is an asset that provides cooperation, reciprocity, and trust (Crosby et al., 2012). To analyze needs of rural communities, informal and formal communication networks should be integrated into the assessment of health needs. According to Becker (2015), research that identifies the needs of rural communities should rely on local leadership to create a collaborative environment between diverse groups of the rural population, such as businesses, schools, and the non-profit sector. Community engagement is an essential component in developing and implementing assessments of community-based health needs. The goals of community engagement are to create a shared vision, identify roles in the community, and to work together to build capacity (Okubo & Weidman, 2000). Since rural communities generally have local pride and a strong sense of independence (Crosby et al., 2012), site visits and face-to-face interactions can help outsiders gain acceptance and support from the community, understand the community dynamic, and build a sense of trust between community members and CHNA consultants (Becker, 2015).

In the State of Georgia, IRS mandates elicited substantial concerns among hospital administrators. They were especially concerned about changes related to the legal obligation of hospitals to their communities. In response to the passage of the ACA and the concerns of hospital administrators, the Georgia Department of Community Health, through the State Office of Rural Health (SORH), engaged the faculty at the Jiann-Ping Hsu College of Public Health at Georgia Southern University (GSU) to assist 18 rural hospitals in complying with the federal mandate. GSU was charged to provide technical assistance to these nonprofit hospitals in comprehensively addressing the CHNA mandate as outlined in the ACA.

A generalized model for completing an assessment is a five-step process that includes the following: (1) Engaging the Community, (2) Defining the Issues, (3) Establishing Community Priorities, (4) Designing a Strategy for

Intervention, and (5) Evaluating the Impact. Steps 1-3 were within the scope of work for the grant awarded to the GSU team. It was the responsibility of each of the hospitals and their governing authorities to complete Steps 4 and 5 in the form of a written implementation and evaluation plan to be submitted to the IRS.

The purpose of this report is to describe the methods, relied upon by GSU's project team, for engaging rural communities in the assessment process for steps 1-3. It was anticipated that a comprehensive diagnosis of community health issues, an established list of health priorities, and an understanding of health assets would empower hospital administrators and other community stakeholders to design and implement effective intervention strategies (steps 4-5) in an effort to improve the health of the population.

## METHODS

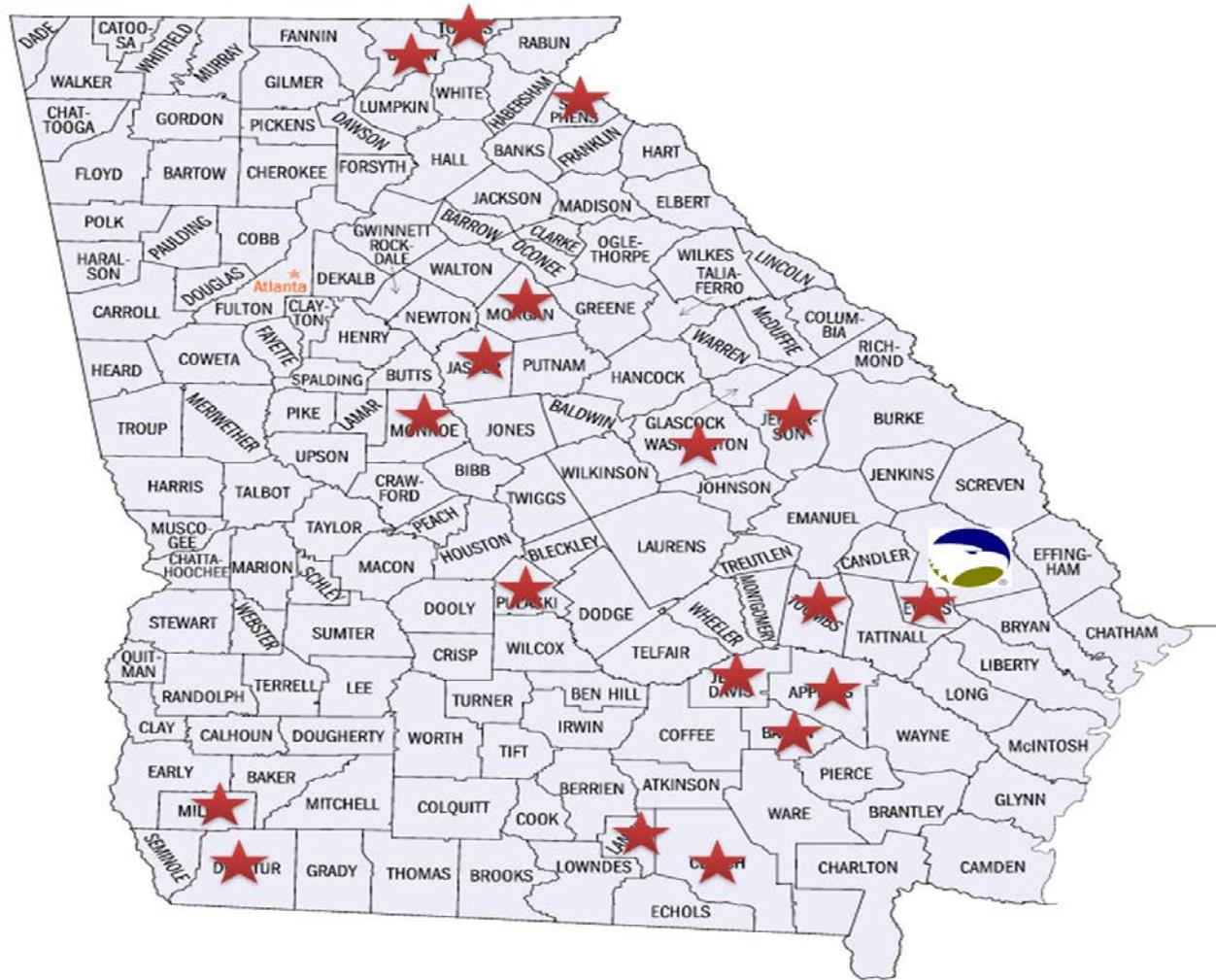
### Assessment Framework

This project utilized an assessment framework that was stakeholder-driven and designed to maximize community participation. In short, the framework involved a series of community and stakeholder meetings, distribution of a community-based survey to assess need, completion of a series of focus groups to establish community perceptions, and an analysis and integration of available secondary data relevant to a hospital system. This information and data allowed preparation of a list of issues that were prioritized at the final meeting in each community.

For all 18 communities, the specific objectives of the project were: 1) to organize steering groups to provide assessment support and guidance; 2) to complete community health assessments (needs identification and assets inventory); 3) to prioritize identified community health issues; and 4) to educate steering group members and community members about the principles and practices of health promotion program planning and evaluation. The project, which was time-sensitive, was conducted in the period of June 2012-July 2013. All project procedures were approved by the GSU Institutional Review Board.

### Hospital Selection

Upon state authorization for monies to be spent to assist rural hospitals in complying with the ACA, the SORH notified all eligible hospitals of the opportunity to participate in this initiative. The SORH selected the first 18 hospitals responding to the offer. Figure 1 illustrates the geographic distribution of communities/hospital systems participating in the CHNA initiative. The distribution of participating hospitals extended from Union, Towns, and Stephens Counties in the north to Miller, Decatur, Lanier, and Clinch Counties in the south.

**Figure 1. Participating Communities/Hospital Systems**

### **Engaging the Community**

Community engagement is defined as “the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people” (Centers for Disease Control and Prevention [CDC], 1997, p.9). The goals of community engagement are to build trust, determine community resources, and enhance communication, since well-designed projects lead to sustainable collaborations, improve community health (CDC, 1997; Shore, 2006; Wallerstein, 2002). Accordingly, to foster community engagement, the GSU team had three face-to-face meetings and numerous telephone and email communications with representatives of each of the 18 communities.

Meeting 1: The purpose of the first meeting was to make personal contact with leaders and other key personnel of each hospital. The project team presented information about the ACA and the role of community assessment, contractual obligations, a conceptual approach to data collection, instructions for clearly defining the medical

service area, the project timeline of activities, and recruitment and membership of a steering group and a community advisory committee (CAC).

Meeting 2: The purpose of the second meeting was to provide CAC members with information regarding project activities and to initiate data collection. This meeting also included an overview of each community’s demographic characteristics and key health-related indicators. Data collection efforts were first initiated by surveying CAC members using a community-based survey.

Meeting 3: For Meeting 3 the purposes were two-fold: 1) to relay the results of data collection to the community, and 2) to prioritize the issues that emerged from data collection. The processes outlined in the description of meetings 1-3 are presented further below.

### **Community Input**

Hospitals were tasked to develop a steering group of 5-7 members to “steer” the CHNA process and were given latitude to include other stakeholders from the community. One member of the steering group was designated as the site

leader, who would be the primary point of contact with GSU. Additional responsibilities of the site leader included disseminating relevant data templates, completing data requests, facilitating recruitment to the CAC, organizing group meetings, facilitating recruitment of a focus group, tracking survey distribution, and general troubleshooting as it related to the CHNA project.

### **Collaborative Efforts and Partnerships in the Assessment**

The CACs were comprised of 15-25 members representing a cross-section of each defined community (target area). The hospitals were instructed to recruit people, or agencies, representing traditionally underserved and minority populations within the target area. In addition, they were encouraged to seek diversity with respect to race, ethnicity, social, economic, and educational backgrounds. As required by the IRS mandate, the CAC was an essential component of community engagement in the process. To formalize the process, the GSU grant team provided each site with a standard letter of intent to recruit CAC members and a description of potential members. The standard letter was to be tailored to each hospital. The site leaders were instructed to discuss potential meeting dates, times and locations with the steering groups to include in the letter before sending it to potential recruits. In working with the steering groups, the site leaders were to identify strategies that would facilitate CAC member recruitment in the community. For instance, some sites chose to publish an article to put in their local newspapers to recruit participants; others developed a list of potential members and divided the names among steering group members to call and invite individuals to take part. For recruitment, other sites used phone calls, emails, letters from the hospital, and word-of-mouth.

### **Description of the community served**

The CHNA target area relied on a county-based definition. However, inclusion or exclusion of a particular county was dependent on the proportion of each hospital's visits or stays. Zip code data from each hospital were used to

establish the general threshold for determining a county as part of the CHNA target. Although there was some variation with regard to each site, service areas were defined based on the proportions of inpatient and/or outpatients stays/visits during the previous calendar year (2011). Zip code data were designated as either "primary" or "secondary". The threshold for a primary designation was whether the proportion of inpatient and/or outpatient stays/visits was equivalent to at least 10% of all visits/stays; proportions of stays/visits less than 10% were designated as "secondary." Counties included in the target area for the CHNA project were only those with zip codes designated as "primary." Members of the Steering Group members confirmed this definition.

### **Analytical method applied in identifying the community needs**

Completion of the CHNA process was dependent on the availability of community-specific resources, the ability of a community to access the resources identified, and the overall readiness of stakeholders. In an effort to standardize data collection across the 18 communities, the CHNA team at GSU developed a series of data collection templates that were used to control variability.

All sites were encouraged to use the data templates to organize specific activities; however, utilization of these templates varied from site to site. Electronic communication was used to encourage sites to complete the templates. Table 1 illustrates the data templates developed throughout the CHNA period and their purpose. In addition to data templates, a series of instruction guides were developed to facilitate progress of the CHNA. The guides included a listing of potential CAC member types, pilot test instructions for survey development, focus group logistics, a suggested community advisory committee recruitment template letter, and an IRS compliance summary.

**Table 1: Data templates developed throughout the CHNA process**

Data Template	Purpose
CHNA checklist	A document that listed all information communities was required to submit in accordance with ACA guidelines for CHNAs.
Hospitals and health districts	A document that contains information on the 18 rural hospitals and health districts.
County health department administrators	A document that contains information on the local health department administrators in the 18 rural sites.
Community Advisory Committee list	A table that contains the name, occupation, business/agency represented, telephone number and email address of CAC members.
Member RSVP list (MTG 3)	A document used by site leaders at each hospital to keep track of attendance of Steering Group and CAC members at Meeting 3.

Data Template	Purpose
Site-specific details	A document used to capture site-specific information about each hospital.
Steering Group bio-sketches	A table with all Steering Group member contacts and bio-sketches, including a paragraph describing their qualifications, occupations and other professional roles and affiliations.
County survey count	A table for site leaders to track CAC members agreeing to distribute surveys following Meeting 2. Site leaders were to update this table when they received completed surveys from CAC members.
Focus group participants information	An Excel spreadsheet with tabs to assist site leaders in keeping track of focus group participants. Site leaders were to call participants 24 hours before the scheduled sessions.
Hospital zip code data	A table that contains service (target) area zip code information for the 2011 calendar year.
Site project timeline	An Excel spreadsheet for site leaders to use with the members of the steering group in developing a timeline that takes into account the end of the fiscal year.

### CHNA Sources and Data

For this project, the GSU team employed quantitative and qualitative data collection techniques. Phase I included quantitative data collection of primary and secondary sources of data; Phase II included primary, qualitative data collection.

### Secondary Data Collection and Analysis

The secondary data reports were generated using data collected from various online sources such as the Georgia Department of Public Health's Online Analytical Statistical Information System (OASIS) (GDPH, 2012), County Health Rankings (County Health Rankings, 2012), the U.S. Census Bureau (U.S. Census Bureau, 2012), and the Georgia Board for Physician Workforce's 2008 Physician Workforce Profile (Physicians Workforce, 2008). Most data related to demographics, physician workforce, preventive care services, insurance rates, and health behavior were reported as percentages. However, all morbidity and mortality data were reported as age-adjusted rates in order to allow for a comparison with the state rates. To reduce variability of all point estimates, reported rates were based on ten-year aggregates (2001- 2010). All data were exported, stored, and managed in Microsoft Excel. In addition, graphs for the secondary data analysis were generated with Microsoft Excel. Examples of secondary data gathered were: 1) demographic characteristics of communities; 2) health and socio-economic indicators; 3) preventive care services; 4) physician workforce; 4) morbidity rates for all cardiovascular diseases, all respiratory diseases, external causes, all cancers, diabetes, all infectious and parasitic diseases; and 5) mortality rates for all cardiovascular diseases, all respiratory diseases, all cancers, all infectious diseases, diabetes, and maternal and child health.

### Primary Data Collection: Survey Development and Distribution

A draft community-based survey was provided at the first site visit. The steering committee was instructed to provide feedback to GSU. Upon receiving the survey feedback from each site, the next step in the process was to make the requested changes so that the survey could be piloted in each community. Instructions for the pilot test consisted of having 5-7 persons in the community who were representative of the service area take the survey. The instructions for pilot testing were sent by electronic mail to the site leader with the revised survey, and each site was given one week to complete this activity. Once pilot testing was completed, the site leader was asked to return the results to GSU either by email or postal mail.

### Primary Data Collection: Focus Groups

Three focus groups were conducted in each community. One was composed of CAC members; the other two were comprised of community members recruited by CAC members. The purpose of this strategy was to minimize bias from hospital staff and to encourage representation of marginalized groups in the community that may not have been included in the CAC membership. This information was presented to site leaders during the process of focus group recruitment. To track focus group recruits, a set of instructions and spreadsheets were developed and sent to all site leaders. This information was provided to assist hospitals in understanding the basics of focus group work, including participants' eligibility criteria, number of recruits per group, focus group set up and locations, the importance of the reminder call to participants 24 hours prior to the scheduled session, and posting focus group procedures. On average, the focus groups were scheduled and held four weeks after beginning collection of survey data. After focus group meetings, the facilitator and note

taker (when available) participated in a debriefing session and completed field notes. All focus groups were digitally recorded and transcribed verbatim by a professional transcription service Verbal, Inc. and subsequently reviewed by the GSU qualitative analysis team for accuracy. Transcripts were analyzed with the qualitative data analysis software program - MAXQDA v10. An *a priori* codebook was developed based on the focus group guide. Transcripts were reviewed and coded by a member of the qualitative analysis team. Codes and emerging themes were discussed continually among this team and agreed on or revised through an iterative process leading to consensus. Coded segments of the transcripts were placed into a qualitative data analysis matrix and separated by codes (i.e. hospital, hospital issues, community, and community issues). All segments from a particular code were read and themes were developed. A grounded theory approach was used to understand the meanings that “community” and “hospital” had for the participants as well as their recommendations to the hospital and participants’ vision for the community as they related to improved community health.

## **Establishing Community Priorities**

### *Prioritization Methods of Needs Identification*

For meeting 3, prioritization of emerging issues was completed in a two-stage process. The first stage was a generalized rank ordering of the issues, discovered during primary and secondary data collection, followed by discussion of those ranks. Any modification to the issues was facilitated. The second stage relied on the Hanlon Method (National Association of County and City Health Officials, 1996), which calculates a Basic Priority Rating (BPR) for each problem identified in the assessment process. This scheme considers four dimensions of each problem and includes the size of the problem (measured by incidence, prevalence, or percentage of the population affected) ranked on a scale from 0 to 10 (denoted as A). The seriousness of the problem (measured by economic loss, impact of other populations, or overall severity as indicated by mortality/morbidity) is ranked on a scale from 0 to 20 (denoted as B), and the effectiveness of interventions (measured by how well previous interventions have worked) is ranked on a scale from 0 to 10 (denoted as C). Finally, a measure known as PEARL (Propriety, Economics, Acceptability, Resources, and Liability) is ranked on a scale of 1 or 2 (denoted as D). PEARL assesses issues of ethics, legality, and economics in addressing a given problem. The formula for calculating the BPR is as follows:

$$\text{BPR} = [(A + B)C/3] D$$

Participants were given a prioritization sheet with instructions and asked to complete a final ranking of the mutually agreed upon issues. Since a PEARL measure assigned as 0 would effectively remove an issue from consideration, participants were asked not to assign a value to the D term in the BPR equation. The results of this exercise yielded the final ranking of issues in each

community. The calculations to obtain the BPR were completed by the project team.

### *Identification of the community assets to address needs of the population*

In rural, low-resource communities, it is essential to identify community-based assets that can mitigate need. In this project, assets were identified through the focus group process. In addition to primary data collection efforts, the project team created an inventory of health-related resources in the target area. The main goal of asset identification was to create a list of the groups and organizations that could have a positive influence on community health. To provide relevant information about tangible community assets, the project team used the online version of the Yellow Pages (Yellow Pages, 2012). The inventory included hospitals, health services, counseling services, youth organizations, community organizations, and rehabilitation services. The final inventory contained names, phone numbers, addresses, and services offered.

## **DISCUSSION**

The purpose of this report is to describe the process of engaging rural Georgia communities in IRS-mandated CHNAs. The success of community-based health needs assessments does not rely solely on hospitals and health departments. Various organizations need to work together by using formal and informal communication to create a common vision and satisfy community needs (Okubo & Weidman, 2000). Financial resources in rural areas are often limited (Crosby et al., 2012, p.4), but community engagement and collaboration between various entities may compensate for low financial resources. Collaboration can also help to divide roles between organizations so that no single entity is overburdened (Sobsey et al., 2014). To ensure community engagement, time must be spent on development of relationships and establishment of trust. Communities should be involved in the CHNA from planning to implementation. Hospital staff are well-versed in regard to collaboration but may not understand how to involve their constituents in relation to assessment (Pennel et al., 2015). By engaging rural communities in assessment of community-based health needs, hospitals can be more effective in resolving community health problems, improving community infrastructure, and creating sustainability (Okubo, & Weidman, 2000).

Public health institutions have a role in partnering with hospitals to complete the CHNA process. CHNA reports often adhere to a medical model (Pennel et al., 2015). Hospital administrators are invested in the health of the community, but their training/perspective may not be consistent with public health approaches. Therefore, partnerships with public health staff may help to expand assessments beyond recommendations that are individualized and medically focused to those that address broader social determinants of health (e.g. education, race/ethnicity, and built environment) and health inequities/disparities. This wider view of the issues is accompanied by the inclusion in the assessment process of

diverse stakeholders. These include public and private educational institutions, law enforcement, business owners, community and faith-based organizations, policy makers, government agencies, and those responsible for city planning. Since hospital administrators may inadvertently omit some of these entities from the CHNA process, they should be prompted to make a list of potential invitees.

## CONCLUSIONS

Rural communities have various functional styles. Since the residents understand the reality of limited resources, they rely on existing networks and partnerships. Understanding the dynamics of rural communities, we recommend that stakeholders embarking on the CHNA process use the following approach: 1) stress the importance of collaboration and reliance on existing social networks in solving community problems; 2) sustain conversations with stakeholders to promote the importance of community health, particularly among community-based organizations; 3) consider shifting central planning authority away from hospitals toward recognized community leaders; 4) structure health assessment processes and protocols to maximize flexibility of community collaborators; and 5) promote adherence to public health and practice-oriented frameworks of community planning (e.g., the PRECEDE-PROCEED [Green & Kreuter, 1999] planning model), design of logic models, and use of appropriate evaluation strategies. In conclusion, engaging diverse sectors of rural communities throughout the entire process of CHNAs can be challenging. This level of engagement, however, provides, for a rural community, the most comprehensive view of its needs and assets which can be used to improve the hospital's contribution to the community and the overall quality of life of its citizens.

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