Health Assessments and Community Engagement – Trinity Health

Community Collaborative use in Health Assessment, Strategic Prioritization and the Implementation of Community Benefit Programming - Lessons from Trinity Health

Presentation by

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Catholic Healthcare – Assessing Need and Acting!

Landing of the Ursulines, by Paul Poincy

Patient Protection and Affordable Care Act New Requirements for Tax Exempt Hospitals

PPACA – Section 501 (r) Requirements

- Conduct a Community Health Needs Assessment every three years;
- Integrate input from broad community interests including those with public health expertise;
- Develop and adopt a formal implementation strategy to address identified unmet needs;
- Develop and broadly publicize charity care and financial assistance policies.

Revised Form 990, Schedule H (Reporting)

- Detailed reporting of program activities by content category;
- Describe whether/how to conduct CHNA;
- Provide evidence of community need in order to document as community benefit;
- Describe how the organization is addressing unmet health needs identified in the CHNA;
- Provide justification for identified unmet health needs that have not been addressed;
- Programs must seek to achieve identified objectives (access to care, enhancing public health, advancing generalized knowledge, removing government burden, etc.

Required Engagement

We are challenged to move community benefit efforts beyond internal processes and include the external community…

- Input from broad interests of community
- Public health expertise or involvement
- Made widely available to the community
- Guidance is now being reviewed by CDC

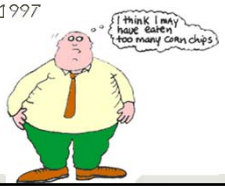
Needs Assessments Will Be Transparent

- Post your CHNA on your website
- Advocacy groups/stakeholder review anticipated
- Detailed reporting on what you did
- Secretary of Treasury must review *each* nonprofit hospital's CB every three years

Why Should We Engage Community Stakeholders?
Hidden Opportunities…

"It is difficult if not impossible to persuade and motivate people to solve a problem if they do not know they are unhealthy or how poorly their health compares to all state residents or to the residents of surrounding Counties."

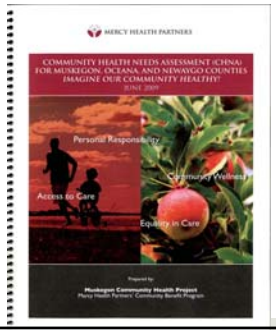
EPIC MRA Executive Report - *1997*



Our Approach -Trinity CHNA Toolkit - 2008

- Establish Meaningful Engagement through Collaborative Effort
  - Seek out Stakeholders: United Way, FQHC's, other hospitals, Mental Health, who also must assess
  - Share costs of process
  - Use Common Benchmarking of Community – e.g. County Indicators
- Emphasize Input from broad interests of community
  - Quantitative – traditional demographics
  - Qualitative – strongly recommend
    - Forums
    - Conversations
    - Sector Affinity (Focus) Groups
- Public health expertise or involvement – targeted local public health
- Make widely available to the community

Community Health Needs Assessment
Shared Benchmarking



- One Assessment
- Reduces Cost
- Common Measures
- Extended Partnership
- Coalition Coordinated
- Measures need

Meaningful Engagement – TH Process

Exhibit 3: Collaborative Partners Resource Grid

Use this tool as a guide to select potential partners to the MO locale likely to assist with data collection and obtaining community input.

Potential Partner	Data Type/Other Assistance	Contact Person	Phone	E-mail
☐ United Way	Human Service Information, Volunteers			
☐ School Districts/IU/ISD	Education, Poverty, Volunteers			
☐ Call-211	Assistance Needs			
☐ Community-Based Orgs. Urban League Community Action Against Poverty Head Start Early Start Volunteer Organizations Service Organizations	Poverty Needs Volunteers – Community Input			
☐ Faith-Based Organizations MO Pastoral Staff Pastoral Committee Council of Churches Others:	Volunteers – Community Input Local Church Attendance data and/or Needs			
☐ Physicians Fed. Qual. Health Cntrs. (FQHC) Other Clinics serving poor Medical Societies Physician Health Organizations MO Primary Care Networks	Health Information, Surveys and Focus Group Participation			
☐ Chamber of Commerce	Community Information Business, Volunteers – Community Input			
☐ Governmental Grantees (e.g., Public Health & Human Services, Housing & Urban Development)	Community Information Needs Data			
☐ City Planning Dept.	Community Information			
☐ County Planning Dept.	Community Information			
☐ Regional Planning Agency	Community Information State's and Local Census Data TA/Contractor			
☐ College/University	Community Information Contractor Volunteers – Community Input			
☐ State Dept. Human/Social Services	Poverty Human Services Info, Risk Factor Surveys			
☐ State Dept. Public Health	Health Data, Risk Factor Surveys			
☐ US Census	Poverty			
☐ Private Data Firms	As Data Contract			
☐ Private Planning/ Marketing Firms	Contractor for Assessment			

Inclusive Community Input

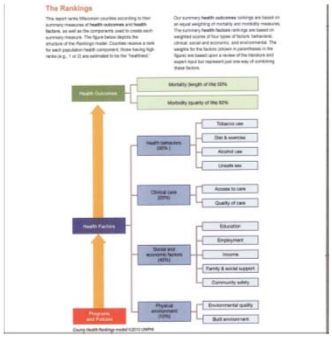
This template provides a variety of approaches and implementation prompts from which to select those who are well-suited to your MO. In conjunction with Exhibit 7 "Collaborative Partners Resource Grid," it can be used to help procure volunteers and in-kind contributions.

Exhibit 7: Community Input & Methods Selection Grid

Input Type	Who? (Interest Sector –see * below)	Lead Person or Community Partner	Sample Size	How? (Hand, mail, phone, web)	Where? (Public, Business, Event, Media)	When?	Cost?
☐ Questionnaires/ Surveys							
☐ Interviews							
☐ Focus Groups							
☐ Expert Panels							
☐ Public Panels							
☐ Town Meetings							
☐ Media Polls							
☐ Individual Stories							

Interest Sectors:
Health Providers
Human Service Providers
Government Offices
Neighborhood Organizations
Businesses
Faith-Based Organizations
Community-Based Organizations
General Public
Seniors
Youth
Disabled
Media
Elected Officials
Educators
Organized Labor

Integration of Public Health Tools



Prioritization of Need

- Identify health needs through CHNA Process
- Develop strategic priorities...let data and input determine agenda
  - Severity of problem: quantitative data/surveys
  - Intensity of need: GeoMapping/spikes/qualitative data
  - #'s of people affected
  - Cost
  - Gaps
- Perceptions of Need
  - Qualitative
  - Stories
  - Reality
- Use of "Super Collaborative"

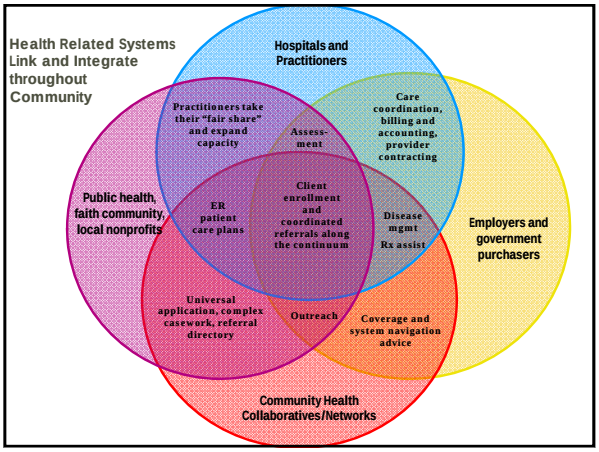
The Action Strategy – After Priority Setting

- Engage existing stakeholders and community members
  - Provide infrastructure and administrative support
- Develop or support coalitions to address CHNA priorities
  - New Programs
  - Enhance Old Programs
  - Initiate Research
- Coordinate collaborative community-based health services
  - Link to provider based health delivery system
  - Link to other resources
  - Target Geographically or Demographically
- Monitor activities and track health outcomes – centrally
  - Develop sustainability and shared investment
- Report community benefit

The Health Project: Modeling Grassroots Engagement in Action

Health Project Collaboration History

- Health Project launched in Muskegon 1993 - Planning
  - Partnership Grant from W. K. Kellogg Foundation (CCHMs)
- Community is Stakeholder in Health Care
  - Inclusive Participation
  - Board representation/Payers, Providers, Consumers
- Outcomes Included creation of Access Health in 1999
  - National model for HRSA SHAP grants
  - 17 communities in 5 states
- Community Benefit relationship established with MHP - 2008
  - Acquired by Trinity Health Systems 2010
  - External Community Benefit Program for Mercy Health Partners
  - Operate as Pilot Site and CB Technical Assistance for Trinity Health
  - Advisory Board of Health Project becomes C B Advisory body

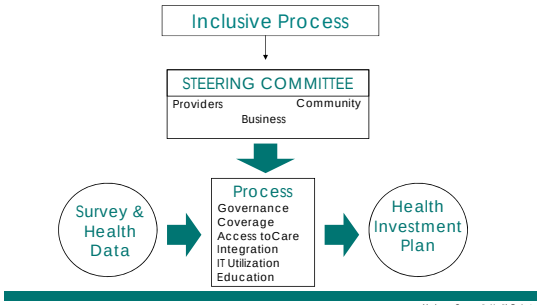


Local Health Coalitions In 1999

- 38% - Expand Health Coverage
- 33% - Prevention Strategies with Public Health
- 30% - Extend Health Services to Underserved Populations
- 27% - Improving Public Programs - Medicaid
- 22% - Enroll People into Health Coverage
- 20% - Reduce Barriers to Providers
- 13% - Improve Rural Health Services
- 12% - Insurance Reform – Health Reform
- 12%- Transportation and Health Access
- 10% - Dental Care
- 9% - Reduce Provider Shortages
- 8% - New Community Facilities
- 8% - Hospital Community Benefits
- 8% - HMO Community Benefits
- 6% - Hospital Closures, Conversions and Mergers

the access project

Convening an Inclusive Process



Muskegon Community Health Project

Hospital MCHP Partnership/Integration

- Hospital CEO on Board
- Board Chair is VP for Medical Services
- Staff involved initiatives
- MCHP facilitates community groups
- MCHP's Director leads Community Benefits Department
- Hospital invests directly in work of Health Project programs
- Health Project aggregates for CB reporting

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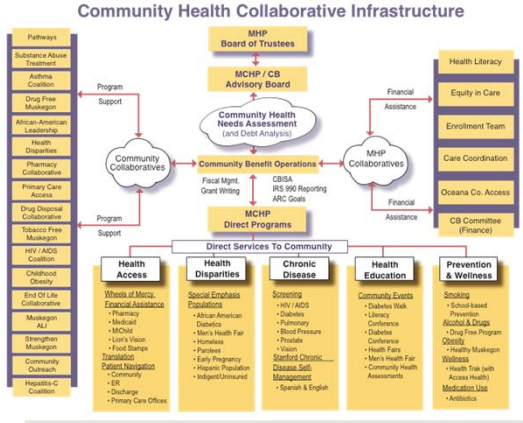
Community Health Collaborative Infrastructure



Linking CHNA to the Web and Social Media

Challenges for Consideration

- Coalition use can be considered "Community Building" and not reportable on the 990h
- Local Public Health is often weak, underfunded, and subject to political agendas of local county governance
- Tendency by federal Policy Makers is to be too prescriptive
- Tracking outcomes – Information systems are inadequate to manage and track what we do
- Questions about Health Reform impact make it difficult to plan
- Evidence based programming limits innovation and opportunity

Process Wins

- Using community health collaborative models and intentional partnerships can improve the community health delivery system
- Community benefit programming can play a key role in targeting and implementing successful community health strategies that impact population health
- Combining the use of community health collaboratives with the goals of the Health Assessment can reduce cost and help to build sustainability
- In communities with competitive medical environments a collaborative can convene as a neutral body for community wide benchmarking

Questions?

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