



ASSESSING COMMUNITY NEEDS

Finalized in 1991, Vision 2000—the vision statement of the Sisters of Mercy Health System—St. Louis (SMHS)—calls on the system to make, by the end of the century, “a significant impact on the health and well-being” of the communities it serves. To respond to communities’ changing needs, SMHS is committed to implementing and advocating for innovative health and social services that improve health and quality of life, with particular concern for the poor.

Seeking ways to assist the poor and underserved is an integral part of the system’s mission. Prompted by a request from the Catholic Health Association (CHA) for hospitals to track and assess community benefit services and contributions, SMHS created the Agenda for Social Accountability. As part of the agenda, each of the system’s strategic service units (SSUs) was called to identify policies and practices for services to the poor, take an inventory of all services without full reimbursement designed to benefit the community at large, and perform a community needs assessment. Information gathered to fulfill the agenda’s directives has become an

A System’s Six-Step Approach Yields Tangible Results

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essential part of each SSU’s strategic planning process.

Now, three years into the assessment cycle, all the SSUs have implemented programs that address health and human service needs identified in their initial assessment. The tangible results include improved access to health services, accelerated economic development, and collaborative community relationships.

Summary To respond to the changing needs of the communities it serves, the Sisters of Mercy Health System—St. Louis (SMHS) is committed to implementing and advocating for innovative health and social services that improve the health and quality of life of communities the system serves. One means to achieve these ends is the Agenda for Social Accountability.

As part of this agenda, each of the system’s strategic service units (SSUs) performs a community needs assessment. Phase one of the assessment consists of six steps:

1. Assign administrative responsibility
2. Review available data
3. Obtain information on community health status
4. Interview community leaders
5. Summarize results in a draft report
6. Incorporate conclusions into the strategic plan

Many of the system’s SSUs have completed the first cycle of the social accountability agenda and are exploring new initiatives for phase two. SMHS is investigating the idea of assessing the functional status of representative samples of community members as another method of measuring health status. And its primary research is broadening to include written surveys and focus groups with select audiences.



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FINDING AN APPROACH

The goal of measuring and reporting the provision of benefits to the community is not unique to SMHS. In 1989 CHA published the *Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint*. Other groups, such as the Voluntary Hospitals of America, the Hospital Community Benefit Standards Program at New York University, and the Internal Revenue Service, have delineated criteria for measuring the amount of benefit an organization provides to a community. The cornerstone of each of these sets of standards is a community needs assessment, followed by a response to identified needs in collaboration with other community organizations. Similarly, the SMHS approach is based on:

- An understanding that the system's mission and vision statements call for improving the health status of the people and communities served

- The assumption that individual assessments can be tailored to local community characteristics and priorities

- The need to incorporate the results into the planning and budgeting processes of both the system and local operating units so that all parties involved can be held accountable for tangible progress on health-related issues

In developing its own community needs assessment process in late 1990, the SMHS Planning Department contacted organizations with established, successful approaches to community needs assessments. Some of the more effective approaches SMHS planners found were the United Way COMPASS process, Mercy Health Services of Farmington Hills' *Special Initiative for the Poor—Community Assessment of Human Needs*, the Daughters of Charity community assessment process, the Third Age Center's "Assessment of Needs of the Frail and Elderly" (prepared for SMHS in 1989), and a traditional

public health approach.

The approaches shared several common characteristics, all of which were incorporated into SMHS's approach. In addition, SMHS developed a standardized set of questions to use in interviewing key community leaders, created a standard report format to facilitate comparisons among SSU assessment results, and decided to phase in the assessment. This phased-in approach allowed SSUs to get community-wide involvement in the process either from the beginning (similar to the United Way method) or later, when they became more comfortable with the assessment process. Given SMHS's preference for decentralized operational decision making, this phasing in accommodated the varying resources and priorities of the SSUs' administrative teams. The SSUs also had the freedom to conduct an initial broad assessment or a more focused study.

THE ASSESSMENT PROCESS

Phase one of the SMHS Community Needs Assessment process consists of six key steps:

1. Assign administrative responsibility
2. Review available data
3. Obtain information on community health status
4. Interview community leaders
5. Summarize results in a draft report
6. Incorporate conclusions into the strategic plan

Assign Responsibility The first step is to assign responsibility for the assessment process to a member of the administrative staff and allocate resources to the project. Designating someone from the administrative staff demonstrates top managers' commitment to the process, ensures the responsible individual has the authority to make expeditious decisions, and provides a liaison to the SSU strategic planning work group, which will ultimately convert identified needs into priority





action programs. The designated administrative staff member can come from almost any area of an organization (e.g., general management, planning, marketing, public relations, social services, pastoral care, or ambulatory services). The manager should, however, have an appreciation of research methodology and an interest in collaborative community development.

Once a leader is designated, he or she selects a needs assessment work group of four to six people. Together with the leader, this group then meets with the SSU's chief executive officer (CEO) to determine the scope of the project (broad or focused on a particular group, such as the indigent or elderly), to develop a work plan (including geographic definition of the study area), and to set a timetable with administrative checkpoints.

At this point the work group and CEO also determine whether the hospital will conduct the assessment independently or involve other groups in the community in the data collection effort. Involving others up front attracts community support from the outset and sets the stage for possible collaborative work later. It can also reduce apprehension that could develop later in the process when the interviewers are out in the community.

On the other hand, involving other groups at this stage can prolong the process because of the politics of getting input from several groups and reaching consensus. Each facility must weigh the pros and cons and decide how best to proceed given the market situation. Most SMHS SSUs chose to expedite the process by initiating it themselves while explaining their intent to other community leaders and healthcare providers and sharing the results. One SSU later formed a community coalition to participate in a more focused follow-up assessment.

Review Available Data The second step in a community needs assessment process is to gather and review data already available. These include demographic and internal hospital data, as well as information on health provider availability and economic development and previous studies conducted by hospital or community groups. The assessment work group should determine where gaps in objective, secondary information exist and organize new efforts to complete this set of data.

Obtain Information on Community Health Step three involves collecting and analyzing data that will add a picture of the population's health to the service area overview. SMHS has developed a list of 19 health status indicators for each needs

assessment. These data are collected from a variety of sources, including state and county departments of health, state centers for health statistics, state departments of human services, the Children's Defense Fund, the U.S. Environmental Protection Agency, the Centers for Disease Control and Prevention, *Northwestern National Life State Health Rankings*, and the *Children's State Health Rankings* publications.

This information identifies specific areas of concern requiring more attention in the interviews in terms of geographic representation, specific needs, or types of community leaders that could best provide supplemental information. When used in conjunction with the demographic information and the results of interviews described in step four, these indicators provide a solid sense of a community's health status.

Interview Community Leaders The fourth step is interviewing key community leaders who are knowledgeable about the needs of the people with whom they are in contact and who can identify existing barriers to resolving identified problems. SMHS interviews a cross section of leaders from a variety of orientations, including representatives from the clergy, schools, local and state governments, police and judicial systems, aging and social service agencies, healthcare providers (public health agencies, physicians, hospitals, ambulatory service providers), and businesses. In addition, key civic groups or social groups are contacted to ensure the views of women and minorities are heard. When the targeted group of potential interviewees is called and invited to participate, a script for introducing the purpose of the interview is used to ensure consistency.

The interview consists of a standardized set of open-ended questions soliciting the respondent's view of overall community needs and the current approaches or barriers to fulfilling those needs (see **Box**). An SSU may add a question or two at the end of the interview about a particular concern it wishes to explore. The respondent is then asked to prioritize those needs and identify any groups or geographic areas that may be experiencing one or more of these problems disproportionately. Interviews usually last less than one hour.

A two- to three-day "blitz" of a community by two-person interviewer teams has been most effective. This schedule, while tiring for the interviewers, helps create momentum, allows the interviewers to begin to see common needs, and prevents scheduled interviewees from talking

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among themselves about the questions, particularly in smaller communities.

After each interview, the team summarizes its information in one report. Within SMHS, the team often consists of one SSU and one system staff member. Experience has shown that having one interviewer familiar with the community and one less knowledgeable about the area is advantageous. The familiar interviewer will catch references to people or areas more easily, but the newcomer can ask for clarifications or follow-up information that sheds new light on the response.

Summarize Results Once the interviews have been conducted, the work group leader sees that summaries of the interviews are collated and combined with the data gathered in step three. The most commonly identified needs and barriers to access are prioritized based on the number of times they are mentioned. However, significant problems may be followed up on, even if they are not frequently mentioned, to see if a closer look is required. Also, if any discrepancies exist between the data collected and the interviews, more research is done to validate the information.

A draft report summarizing the findings is then developed and circulated to the work group for comments. Each person reviews the report with an eye to inconsistencies or misinterpreted interview responses. After the draft is reviewed and edited, the final version is produced.

Incorporate Results into Strategic Plan The last step in the assessment process is incorporating the results into the SSU's strategic planning process. The most effective way to do this is to have the administrative representative who coordinated the process present the findings to the SSU planning team as part of the review of the local environment. At this point the team discusses the findings and begins to focus on those which they believe demand a higher-priority response.

Invariably more community needs will be identified than any one organization, or even a group of organizations, can meaningfully address. Several SMHS SSUs found that the community was more concerned about needs other than healthcare (e.g., economic development or education). Acting on its own, the SSU might too quickly set aside those needs outside healthcare as not being within its usual purview, despite the problems' long-term health implications for the population.

For example, in one region the community was concerned with the high number of high school dropouts. A traditional healthcare organization

would not have seen this as a health problem. However, the SSU recognized a connection between low rates of high school completion and poor health. Interviews revealed that some students failed to complete high school because of years of poor nutrition. Other students dropped out because they believed their future was hopeless even if they graduated. In response, the SSU decided to sponsor college scholarships for employees' children and babies delivered at the hospital. The SSU also collaborated with other community groups to bring a specialty mathematics and science high school to the area.

Values are also important criteria for prioritizing needs. At one of the SSUs, the planning team

SMHS COMMUNITY BENEFIT INTERVIEW QUESTIONS

1. Would you describe your organization and what your role is?
2. a) What four or five human needs do you see in this community overall as being unmet? Human needs could include educational, employment, nutritional, housing, social supports, and healthcare needs and should not focus only on the needs of the poor.
b) What are the barriers to having these needs met or what prevents people from seeking or getting assistance with these needs?
c) How would you prioritize these needs in terms of importance and need to be addressed?
3. a) Are there geographic areas or groups of people in the community that are more needy than others?
b) Are their needs different from those you have already identified? If so, what are some of the specific needs?
4. a) Of the services currently being offered, what improvements, if any, could be made to healthcare as it is delivered in this community/county? Why?
b) Are there any health services that are currently not being offered that you think should be?
5. a) Are mental health needs being met in this community?
b) Do you know of improvements which could be made to the services now offered by psychiatrists, psychologists, other mental health professionals, or healthcare organizations?
6. Which needs do you think could be addressed by [hospital name] and other organizations working together?
What role do you think [hospital name] could plan in this collaborative effort?
7. Is there anyone else that we should speak to about the needs of this community? Do you know how we could contact them?
8. Can we contact you for any follow-up questions we might have?



ranked the identified community needs against key values to help decide which needs to address. In all cases the SSU determines what resources it has available and which of the community's myriad needs it is best able to address.

Allowing sufficient time to process the results and encouraging collaboration with other groups can lead toward the adoption of action programs that address higher-priority community problems.

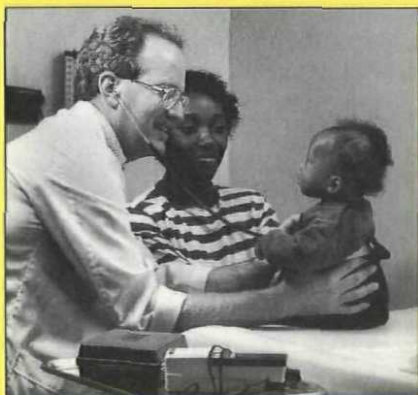
IMPROVING COMMUNITY HEALTH

Phase two (the second three-year cycle) is under way for many SMHS facilities. This second phase is taking different forms, depending on each SSU's objectives and the perceived gaps in knowledge or involvement in the community.

One SSU hired teachers during the summer as an interviewer corps to survey a cross section of area residents. The teachers' involvement both broadened community involvement in the needs assessment and improved the effectiveness of the SSU's efforts—a need it identified in phase one. Another SSU is focusing on the Medicaid and uninsured populations, learning how to reach them and provide a continuity of primary care services. Still another is broadening the geographic focus of its original assessment, reaching out to surrounding communities to meet a specific need.

The data gathered in phase one will be updated and specific health status indicators compared with those from three years ago. SMHS is now exploring the feasibility of assessing the function-

SMHS COMMUNITY BENEFIT ACTIVITIES



Well-baby follow ups are a key service of the Primary Health Care Initiatives Program.

The Sisters of Mercy Health System's (SMHS's) strategic service units have many success stories to share about their collaborative approaches to addressing community needs and improving health status. Each one has tailored its responses to the unique situation of its community.

KANSAS PROJECTS

In southeast Kansas the community needs assessment process validated area residents' key needs: deterioration in the economic and business environment, insufficient primary care in rural

areas, and large numbers of poor and elderly without adequate access to medical care. Mercy Hospitals of Kansas first responded by establishing four rural health clinics in counties neighboring Fort Scott and Independence, areas designated as having inadequate primary care. These clinics are staffed by midlevel practitioners (i.e., advanced clinical nurse practitioners or physician assistants) who are supervised by physicians. In addition to bringing medical care to underserved areas, the hospitals have established transportation programs to bring residents to the hospitals and their physicians' offices.

Mercy Hospital in Fort Scott addressed the community's economic development needs by taking an active role in forming a county coalition consisting of representatives from city and county government, the hospital, the local community college, and a local business development group. Together they revised the economic development plan for the area, received state funding to devise a county plan, and took over operation of the local industrial park. The coalition has already convinced one business to expand operations in the area, which will provide new jobs over

time for more than 60 people. In the Independence area, a similar coalition developed plans for a new technical school and purchased a facility to house and "incubate" new businesses in the area. In addition to being an active participant on the coalitions, Mercy Hospitals of Kansas made a three-year grant to both coalitions to partially fund these efforts.

In Independence, a community coalition of churches, healthcare providers, and other agencies came together to address the factors leading many elderly to enter institutions rather than remain in their homes. Because loneliness was found to be one important factor, the coalition developed a volunteer visitation program, with Mercy serving as "match-maker" between the elder and a visitor and arranging the form and timing of the visits to best meet the needs of both.

PRIMARY HEALTH CARE INITIATIVES, LAREDO, TX

Mercy Regional Medical Center in Laredo, TX, began its Primary Health Care Initiatives (PCHI) with a prenatal assistance program to give women the medical attention they needed before and after giving birth. Before this initia-



al status of a representative sample of community members as another, perhaps more direct, measure of health status. The primary market research is broadening to include focus groups with select audiences and phone or mail surveys.

As the healthcare delivery system changes over the next several years to embrace the concepts of universal access and health status improvement, organizations providing care must understand the needs of the communities they serve, the barriers to problem resolution, and how to counteract the barriers. To remain vital corporate citizens responsive to these needs, providers must take a broad-based collaborative approach to problem prioritization and resolution. The community needs assessment process embraced by SMHS

provides a means by which that understanding and action can occur.

The viable healthcare organization of the future will be required to demonstrate that it can improve the health status of the community it serves. These community needs assessments, by incorporating factual data collected over time, will provide solid evidence that SMHS healthcare providers are indeed improving their communities' health. If efforts to meet real healthcare needs continue at this pace, by the year 2000 the Sisters of Mercy Health System will be able to look back and document that it has satisfied the challenge of its Vision 2000—meeting community needs and improving health status in collaborative and innovative ways. □

tive, Mercy received 8 to 12 walk-in obstetrics patients per week who had no history of prenatal care. After this program was put in place, that number dropped to an average of four women per week, most of whom came from Mexico. A natural outgrowth of this program was a well-baby follow-up service. Mercy Regional Medical Center and staff pediatricians provide continuing check-ups to infants delivered through the prenatal program to ensure their healthy development and immunization. Social workers with the program assist new parents in finding health and nutritional programs that serve low-income families.

Mercy Regional Medical Center also collaborated with the Gateway Community Health Program (a migrant health worker initiative) to establish two primary care clinics in Laredo. The medical center provided the facilities for Gateway to relocate its services to mid-Laredo, where a large number of the community's healthcare poor reside. A second clinic was opened in south Laredo, where the poorest persons in the area live in *colonias*—mini-communities without sewers or running water in the homes. Mercy provides screening and outreach services, diagnostic labora-

tory and x-ray services, rotating physician specialists and case workers to help qualify people for Medicaid, and other financial assistance. Gateway provides the primary care physicians to staff this clinic.

ADVOCACY IN MISSISSIPPI

The system itself has also conducted community needs assessments. When the decision was made to discontinue sponsorship of Mercy Regional Medical Center in Vicksburg, MS, the system conducted an in-depth assessment to identify unmet health and human service needs of Mississippi residents. The most frequently mentioned and serious needs were primary care, illness prevention, and related education and counseling services. The system also identified a need to work with state legislators and regulatory agencies to better serve community residents and improve their access to healthcare.

As a result of the assessment, SMHS undertook two initiatives. The first, in primary care, was to collaborate with the Coastal Family Health Center, a not-for-profit organization operating five clinics along the Gulf Coast. SMHS teamed up with Coastal to bring primary care ser-

vices to smaller, less-accessible communities through a mobile van. The van takes primary care and social services to low-income housing centers, Head Start programs, senior citizen centers, and areas identified as underserved. In many of these communities, residents are without transportation or have personal or health problems that make it difficult for them to travel to healthcare facilities.

The second initiative sponsored by SMHS in Mississippi is a formalized advocacy effort to improve health policies, practices, and funding for the poor. The Mississippi Health Advocacy Program is headquartered in the state capital of Jackson. SMHS employs an executive director and assistant to organize and provide a multifaceted program that identifies specific issues to be addressed, coordinates efforts with other advocacy groups, assists local communities in organizing and making their needs known, educates legislators and other key policymakers, develops an effective media relations program, establishes research and data collection methods, and identifies and communicates opportunities for involvement by Mercy sisters. The program has received national, state, and local media attention.