ENGAGING COMMUNITY MEMBERS TO IMPROVE COMMUNITY HEALTH

Lessons from State Medicaid ACO Implementations

JESSICA CURTIS, JD, AND KRIS WIITALA

Imagine this. Your family has been selected to receive a free home renovation from HGTV. Elated, you spend countless hours scouring the Internet for ideas and sketching out floor plans to improve your living space. Because you know the budget is limited, you create a list of priorities that you want to see tackled first. On demolition day, the show's producers breeze through the door, directing their crew to different parts of your home. Before their harried assistants can rush you out the door, the producers sit and talk with you about your list: since they can't accommodate every wish, what do you really need to have happen? What do you really want? What trade-offs are you willing to live with to make it work? Later, during the big reveal, you are speechless as you walk through your beautiful, functional new space. The producers have worked their magic again, bringing your vision to life.

This scenario is an apt analogy for the type of experience many hospital staff and community partners hope to create when working on community health needs assessments. The CHNA is a federal requirement nonprofit hospitals must follow to assess and address community needs as part of their community benefit planning. At its core, the CHNA is simply a process for identifying community health needs based on fundamental public health principles of data collection, transparency, and a solid understanding of the importance of working in coalition with community.[1] When implemented successfully, the CHNA process can help hospitals create open lines of communication with community stakeholders and members, giving staff information in real time about the community's priorities and painting a fuller, more accurate picture of the strengths and challenges different sectors of the community might face. It is a powerful opportunity to leverage hospital data, public health expertise and community insight — particularly from groups that have faced discrimination, poverty, language or opportunity barriers and other challenges — to drive programming that addresses the root causes of poor health at the local level.

Federal regulators understand the impact hospitals can have if they engage community members and residents in the CHNA process. That's why, under federal law, hospitals must actively seek and consider input from people who represent the "broad interests of the community served" when conducting their CHNAs — including members of medically underserved, low-income and minority populations. This approach leverages and respects local knowledge and priorities, and it encourages hospitals to structure their community engagement efforts to hone in on the voices and perspectives of the people living in their target communities. But is "community input" enough? How can hospitals engage communities in ways that will guarantee a sense of shared ownership of the CHNA?

A recent Community Catalyst study of consumer engagement in another health care context — accountable care organizations — may help to shed some light.[2] Community Catalyst describes itself as a national non-profit advocacy organiza-

tion working to build the consumer and community leadership that is required to transform the American health system.[3] An ACO is a network of providers that contract together to provide coordinated care for a defined patient population.[4] ACOs generally assume some level of financial risk based on the health outcomes of these patients, with payment mechanisms tied to outcomes instead of volume. Some ACOs get bonus payments for meeting certain quality targets. Because reimbursement is connected to the patient's overall health outcomes, many ACOs provide a full suite of medical and nonmedical services (transportation, for example) that can improve their plan members' health and quality of life. It's a tall order, and the stakes are high for the ACO and patients — particularly those patients who have more severe or chronic health problems that routinely require medical intervention.

To make sure patient perspectives are adequately considered during decision-making, state Medicaid programs and individual Medicaid ACOs often are required to include mechanisms for gathering consumer input. Our study looked at the formalized structures and practices for consumer engagement in Medicaid ACOs in six states. We also conducted interviews with consumer health advocates in the six states to understand their perspective on the successes and challenges of consumer engagement in ACO design and implementation. We found that state requirements for consumer engagement vary widely — and so did the experiences of consumer representatives. In our report, we summarized the key lessons learned and best-practice suggestions by consumer health advocates for meaningful engagement.

Below are some suggestions tailored to hospital community benefit staff seeking practical ideas for improving the way community members and organizational partners experience the CHNA process.

Mind the (funding and resource) gaps: Provide financial stipends or support for sustained community involvement. Community members and professional health advocates need some financial support to sustain over time their involvement in a consumer engagement initiative. Possibilities could include providing modest stipends for community members who are volunteering their time to participate in a focus group, or paying for staff time so that community-based organizations can maintain a presence in collaborative work throughout the entire CHNA process.

Dig deep to ensure representative recruitment. Engagement is the most meaningful when community members are representative of the population the health care entity serves. In a CHNA context, this means that hospitals can and should develop community engagement and outreach plans that include grassroots community members — not just public officials or "grasstops" community leaders — from the target populations they have identified and defined in their CHNA.

Make engagement an easy choice. Getting involved in a CHNA can require a significant time commitment that makes participation overwhelming or unappealing, especially for community members. To the greatest extent possible, hospitals should make it easy for community members to participate. Some considerations, based on our report, include:

- Holding meetings in central locations within the target community, not on the hospital campus
- Offering a meal, transportation, child care and translation services for limited English proficiency speakers
- Providing advance notice and agendas in multiple languages
- Coordinating requests for input and spreading them out over time
- Offering ways for community members to join remotely or share their input outside of scheduled meeting times

Be open to community leadership and influence. Our study found that health advocates felt their participation in Medicaid ACO implementation initiatives were worthwhile when they clearly had some measure of power and influence over decision-making and outcomes. Several participants expressed frustration over being limited to offering recommendations and nothing required the ACO to follow through on their suggestions. As one consumer advocate put it, "There weren't barriers to our participation. There were barriers to our influence."

Within the context of a CHNA, similar dynamics can emerge. Community members and organizations often are drawn to participate in a CHNA because they believe their participation will give them an opportunity to raise a concern or identify new champions or resources for their issues. But for many hospitals, the CHNA is a management tool that drives internal decision-making about a limited pool of resources.

Hospital community benefit staff may have

very little ability to address community priorities that don't align with hospital goals and little influence with senior managers and executives who decide how resources get spent. It is critically important that hospital staff talk openly and honestly with community members and community-based organizations about the internal dynamics that will govern how hospital resources flow, the limits of their own decision-making abilities, and even which priorities are selected in the CHNA report.

Although this conversation may not be easy, it will go a long way towards establishing trust. Over time, hospital staff also should explore ways to win internal support for making the CHNA process more reflective of community priorities — that is, moving the process along the "community engagement continuum" from merely seeking community input to sharing the planning, decision-making and implementing with community partners.[5]

Invest in skill-building and training to bring community members up to speed: Our study found that consumers need support and sufficient time in order to meaningfully participate in ACO initiatives, which often involve new jargon and technical topics. Although the community health issues that arise in a CHNA may be less complex, they are still dense. Even the process of sitting in a meeting may be new to some community members.

Hospitals can treat this challenge as an opportunity to build community health leadership and advocacy skills. For example, Community Catalyst has a range of tools to assist health care entities that want to help community members develop their leadership skills in this way. Hospitals also can consider partnering with a local- or state-based organization to provide training and skill-building opportunities to community members involved in the CHNA.

We hope these lessons learned from the world of Medicaid ACOs offer some insight into common challenges community partners face when offering input to health care institutions, along with useful ideas for designing a CHNA process that truly works for the hospital and its community. As we look to the future, it is more critical than ever that community members and organizations find ways to partner with local hospitals.

For hospitals, too, having access to informed, engaged community members and community-based organizations will be essential to identifying and successfully meeting today's local health challenges. Trusted community leaders often have creative ideas for reaching underrepresented voices in their neighborhoods. And, they can sound an early alarm if hospital priorities or programming seem to be falling short of the vision and values held by community members hospitals wish to serve.

This wisdom is a gift that cannot be bought or found lurking in even the most detailed hospital or public health data. Developing processes and practices that enable community members and organizations to participate in CHNAs — and keep them coming back to the table in future years — is possible with a little foresight, planning and investment. We look forward to seeing what hospitals and community partners will accomplish together in the years ahead.

JESSICA CURTIS directs Community Catalyst's Hospital Accountability Project.

KRIS WIITALA is a program and policy associate for the Center for Consumer Engagement in Health Innovation, an initiative of Community Catalyst, Boston.

NOTES

1. Centers for Disease Control and Prevention, "Community Health Assessments and Health Improvement Plans," State, Tribal, Local and Territorial Public Health Professionals Gateway, www.cdc.gov/stltpublichealth/cha/plan.html.

2. Kris Wiitala, Margaret Ann Metzger and Ann Hwang, *Consumer Engagement in Medicaid Accountable Care Organizations: A Review of Practice in Six States*, (Boston: Center For Consumer Engagement in Health Innovation, September 2016). www.communitycatalyst.org/resources/publications/document/ConsumerEngagementMedicaidACOs.pdf?1474915709.

3. Community Catalyst, website. www.communitycatalyst.org/about.

4. Center for Health Care Strategies, "Medicaid ACOs: State Activity Map," June 2017. www.chcs.org/resource/medicaid-aco-state-update/.

5. Agency for Toxic Substances and Disease Registry, "What Is Community Engagement?" in *Principles of Community Engagement*, 2nd Edition, (Washington, D.C.: U.S. Government Printing Office, July 2011). www.atsdr.cdc.gov/communityengagement/pce_what.html.

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